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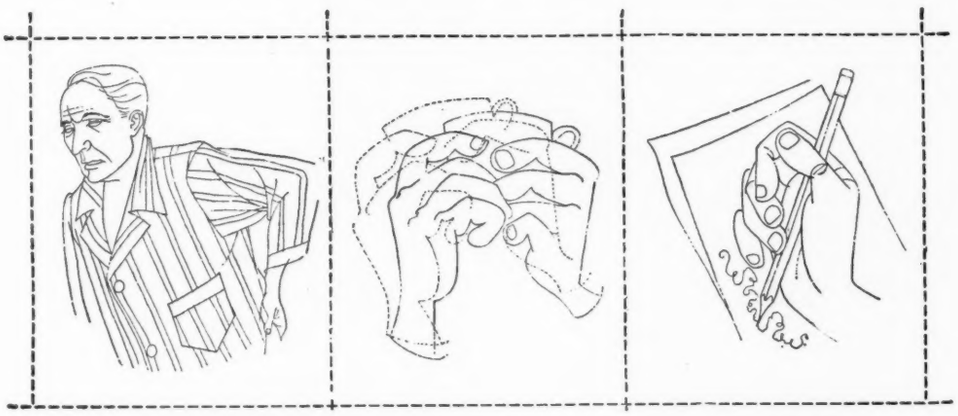

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of December 10, 1952

Sixty-five items were presented to the Executive Committee of The Council on December 10. Chief in importance were:

- **Reports on Beaumont Memorial Fund.** Otto O. Beck, M.D., reported total contributions to December 9 of $25,119.40—an average of $11.80 from 1,680 contributors. Dr. Beck felt that at least 60 per cent of the doctors of medicine of Michigan should become contributors to the Beaumont Memorial; he urged more effort on the local level, with stimulation from members of the MSMS Council.
- **Financial reports** were presented, studied and approved. Bills payable were presented and payment was authorized.
- **Report on AMA Clinical Session,** Denver, December 2-5, was presented by Council Chairman William Bromme and Delegates' Chairman, Wm. A. Hyland, M.D., including résumé on the important resolutions and actions of the House of Delegates and on the Public Relations Conference of December 1.
- **Committee reports**—the following were given consideration:
  (a) Cancer Control Committee, meeting of November 13; (b) Mental Hygiene Committee, November 19; (c) Emergency Medical Service Committee, November 19; (d) Exhibit Managers and MEA Officers Meeting, November 19; (e) Liaison Committee With Veterans Organizations, November 25; (f) Maternal Health Committee, December 2; and (g) Geriatrics Committee, December 2.
- **Representatives to attend the Governor's Conference on Veterans Administration,** to be held in Lansing, December 16, in the Senate Chamber of the Capitol, were appointed: President R. J. Hubbell, M.D., Kalamazoo; President-Elect L. W. Hull, M.D., Detroit; Council Chairman William Bromme, M.D., Detroit; Speaker R. H. Baker, M.D., Pontiac; and Councilor G. W. Slagle, M.D., Battle Creek.
- **The Secretary presented various recommendations** and received approval of a list of associations, hospitals, and institutions to be invited to display scientific exhibits at the September, 1953, MSMS Annual Session in Grand Rapids.
- **The Secretary reported** that the Michigan Health Officers Association had accepted invitation to meet coincident with the 1953 Michigan Clinical Institute, Detroit, on March 11; also that a meeting for Residents, Internes and Senior Medical Students would be held in Detroit at the time of the MCI, on March 11.
- **G. B. Saltonstall, M.D.,** Charlevoix, Chairman of the MSMS Committee on AMEF, was authorized to attend the annual meeting of the American Medical Education Foundation in Chicago January 25 as official MSMS representative.
- **Representatives to the regional workshop meeting on Improvement of Nursing Service** to be held in Kalamazoo January 29, 1953, were authorized to be appointed by the Councilors covering the geographic area of the meeting.
- **Report on Michigan Study Commission on Migratory Labor** and recommendations of E. F. Sladek, M.D., Detroit, MSMS representative on this Commission appointed by the Governor, were received and referred to the MSMS County Societies Committee.
- **Editor Wilfrid Haughey, M.D.,** stated THE JOURNAL would publish the names of new Doctors of Medicine as Michigan licenses are granted to them. He also announced the details of the Medical Jurisprudence Number of JMSMS (April 1953).
- **Treasurer Wm. A. Hyland, M.D.,** reported on MSMS bonds and income therefrom.
- **The Executive Committee of The Council** reiterated the MSMS policy of not permitting publication of any MSMS Committee actions or recommendations prior to approval of Committee minutes by The Council or by its Executive Committee. Since actions and recommendations of an MSMS Committee are not official until approved by The Council or by its Executive Committee.
- **Legal Counsel J. Joseph Herbert's report** included opinion re confidential communication in connection with poliomyelitis cases.

THE PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

The Commission on the Health Needs of the Nation appointed by President Truman under the chairmanship of Dr. Paul Magnuson, has been surveying medical problems for about a year. The commission, which expired on December 29, made its first report on December 18, 1952, issuing the first of five volumes. The first volume contains all recommendations. The report is a middle-ground proposal for solving one of the hottest issues—how to pay the doctor's bill.

The commission proposed a 1½ billion dollar annual outlay of federal and state funds to bolster

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PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

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voluntary insurance plans covering the costs of hospital and medical care for all the nation's people lacking full ability to pay.

Administered by States

The program would be administered chiefly by the states, which would match federal money dollar for dollar.

It differs both from a plan unsuccessfully espoused by President Truman and a rival proposal of the American Medical Association.

President Truman, since 1945, has vainly plugged for a federal system of pre-paid sickness insurance for 125,000,000 wage-earning Americans—to be financed by a compulsory tax on employes and employers, along the lines of the social security system.

The AMA has termed Truman's proposal "socialized medicine," and has campaigned for the extension of "voluntary" insurance plans—that is, plans which a person can purchase if he wishes.

In Chicago, Dr. George F. Lull, secretary and general manager of the AMA, said the association will have no comment on the commission's proposals "until we have had an opportunity to study the report in detail."

"A careful analysis will be made as soon as copies of the commission's report are received," Lull said.

The commission, appointed in November of 1951 to assess the nation's health needs, and to make recommendations as it saw fit, collected some two million words of testimony from experts in various fields during hearings held in Washington —and close to another million words in hearings throughout the country.

Not Up To Standard

One of its main findings was that "despite superior medical service and low death rates, Americans are not enjoying as good health as might be expected in this country."

One prime reason, the commission said in its report to Truman, was that people in low income groups can't afford adequate medical care—even on present pre-payment plans.

The commission, whose formation was termed by the AMA a "political expediency"—and was more vehemently criticized by individual leaders of the AMA—also called for:

1. The training of more doctors, nurses and other health personnel. The commission estimates there may be a shortage of anywhere from 22,000 to 45,000 doctors by 1960 depending upon the success of proposed methods of organization on a "group" basis in the meantime, unless more doctors are trained.
2. Construction of more hospitals.
3. Increased medical research.
4. Support of industrial health and of migratory workers.

Would Double Outlays

The commission estimated the federal government's share of such a program would total $1,016,000,000 annually, including the $750,000,000 for grants to states in the voluntary pre-payment plan. This would double federal health outlays.

A spokesman for the commission told a reporter that with the exception of $100,000,000 proposed for aid to medical schools, another $20,000,000 for medical research and still another $10,000,000 for federal aid in organizing medical services on a regional basis, all other funds would be on a matching basis with the states.

That is, the separate states would be expected to ante up a sum equalizing the amount placed in the kitty by the federal government—but with richer states paying more than poorer ones.

On Local Basis

On the pre-payment of medical care, the commission proposed that direct handling of the plan would be on a local basis, with federal aid money being filtered down through the states, but with the federal government checking up on the qualifications of proposed plans through a new governmental department of health and security.

This department would carry cabinet status.

The commission also proposed that a federal health commission be set up permanently to study national health problems on a continuing basis.

A three-member minority of the 16-member commission entered a dissenting opinion with respect to the majority's recommendations for financing health services on a pre-paid basis.

This minority group, which includes Walter Reuther, president of the Congress of Industrial Organizations, criticized leaving participation in the proposed health insurance program "to the option of each state."

The minority group declared that any such legislation "would discriminate against those persons whose states chose for any reason not to participate."

The group recommended that participation of each state be assured by federal statute, rather than on the voluntary basis recommended by the majority of the commission—or that the federal government take full care of the plan in states not participating.

Failing either of these, said the group, the compulsory tax plan espoused by Truman should be adopted.

The commission was headed by Dr. Paul Magnuson of Chicago and included seven doctors from university staffs, representatives of hospitals and

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nurses, consumers organizations, farmers, labor and the public.

The AMA president, Dr. Louis H. Bauer, said the one particular recommendation is "so obviously objectionable, we wish to call attention to it immediately."

He said the recommendation is on Page 148B, Volume 1 of the commission report. He said it reads:

"Funds collected through the OASI (Old-Age and Survivors Insurance) mechanism be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance group, under a plan which meets federal standards and which does not involve a means test (a test to determine ability to pay)."

Hits Federal Control

"In this single recommendation," Bauer said, "the commission proposes that funds collected through the social security system be used to purchase medical care for beneficiaries covered by that system.

"Under this plan," he continued, "the federal government, through payroll deductions, would pay directly for the medical care of an ever-increasing segment of our population, and our health services would inevitably be controlled by big government."

Commission officials told a reporter the federally aided prepayment insurance plan would be aimed primarily at helping people with annual incomes of under $3,000.

But it would also provide full costs for people having no income and give some aid to those people making more than $3,000 a year but still unable to pay the full cost themselves, officials said.

How Plan Would Work

In general, here's how the plan would work—as explained in the report and amplified by commission officials:

Complete medical and hospital service and some dental service would be provided for all people who wanted it on a pre-paid basis, whether they paid the insurance premiums themselves, or got some or all financial help from the federal-state plan.

Regional authorities would be set up in the various states for the direct operation of the plans, but the insurance plans would be subject to approval by state and federal authorities. Doctors would not be in the majority on regional authority boards.

The federal government would pay full insurance costs for certain people now entitled to federal assistance, such as recipients of old age and survivors insurance. The states would pay full costs for certain people already entitled to other kinds of state benefits. All other people requiring some financial aid would get it from the pooled federal-state fund.

Commission Members

The full membership of the commission:

Dr. Magnuson, Chicago orthopedic surgeon and one-time chief of medical services for the Veterans' Administration, chairman; Chester I. Barnard of New York, chairman of the National Science Foundation, vice chairman; Dr. Lester W. Burket, dean of the University of Pennsylvania's School of Dentistry; Dr. Dean A. Clark, general director of the Massachusetts General Hospital, Boston; Dr. Donald M. Clark of Peterborough. N. H., a lecturer at Boston University School of Medicine; Dr. Evarts A. Graham, professor emeritus of surgery, Washington University, St. Louis; Albert J. Hayes of Washington, D. C., president of the International Association of Machinists; Joseph C. Hinsey of Scarsdale, N. Y., dean of Cornell University Medical College; Charles S. Johnson of Nashville, Tenn., president of Fisk University; Dr. Russel V. Lee of Stanford University School of Medicine; Elizabeth S. Magee of Cleveland, general secretary of the National Consumers League; Clarence H. Poe of Raleigh, N. C., president and editor of *The Progressive Farmer;* Lowell J. Reed, vice president of the Johns Hopkins University and Hospital; Marion W. Sheehan of New York City, director of the National Committee for the Improvement of Nursing Services; the late Dr. Ernest G. Sloman, dean of the College of Physicians and Surgeons, a School of Dentistry in San Francisco, who died during the year; and Reuther, the CIO president.

Magee and Hayes joined Reuther in the minority report regarding the prepayment plan.—Condensed from Press reports, December 18, 1952.

Ten Principles

The commission offered this ten-point statement of "principles" to guide public thinking about health:

1. Access to the means for the attainment and preservation of health is a basic human right.
2. Effort of the individual himself is a vitally important factor in attaining and maintaining health.
3. The physician-patient relationship is so fundamental to health that everyone should have a personal physician.
4. The physician should have access to proper facilities and equipment, affiliation on some basis with a hospital, and the help of trained personnel in order to fulfill his part in providing comprehensive health service.
5. Comprehensive health service includes the positive promotion of health, the prevention of

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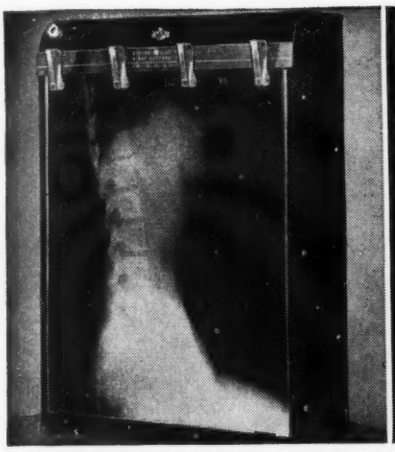

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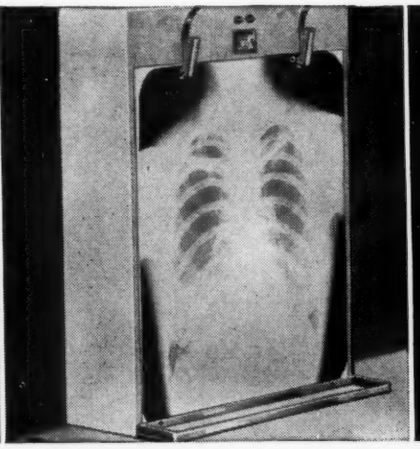

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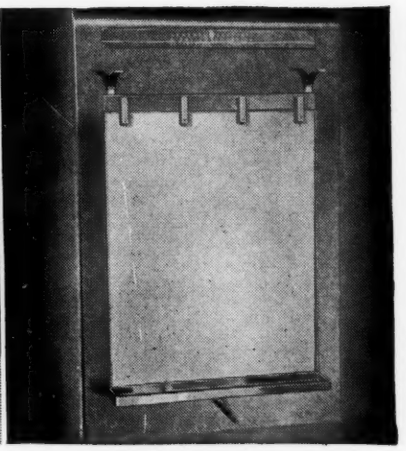

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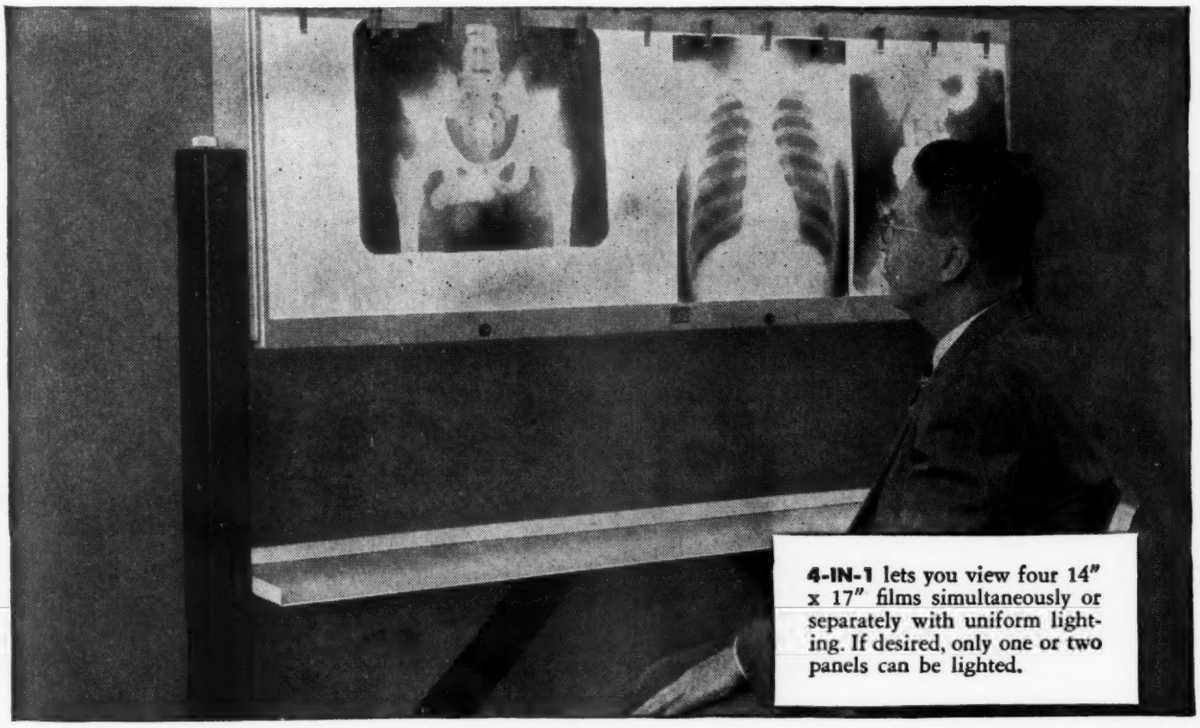

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disease, the diagnosis and treatment of disease, the rehabilitation of the disabled—all supported by constantly improving education of personnel and a continuous program of research.

6. Comprehensive health service is the concern of society and is best insured when all elements of society participate in providing it.

7. Responsibility for health is a joint one, with the individual citizen and local, State and Federal governments each having major contributions to make toward its fuller realization.

8. The American people desire and deserve comprehensive health service of the highest quality and in our dynamic society the means can be found to provide it.

9. The same high quality of health service should be available to all people generally.

10. A health program must take into account the progress and experience of the past, the realities of the present, and must be flexible enough to cope with future changes.

Creation of a Cabinet-rank Department of Health and Security

The commission decided that the interrelationship between federal health functions and general security functions ". . . is so fundamental that it indicated the desirability of combining" them. (Commissioners Evarts A. Graham and Russel V. Lee dissented, urging instead a cabinet Department of Health. Commissioner Joseph C. Hinsey advised more study.)

Also at the top level would be a permanent Federal Health Commission, similar to the Magnuson Commission, whose duty it would be to observe and report annually on all national health matters. It would contain no United States or state employes and not more than half of its members could be professional persons.

The tentative budget sets aside $1 million to finance the Commission and federal programs for industrial health and migrant workers, but does not give a breakdown of costs for the three operations.

PHYSICIANS, SKILLED LABORERS SHOW COMPARABLE HOURLY EARNINGS

The concept of overtime work at overtime pay, although familiar to most Americans, is seldom applied to a profession like medicine. If it *were* so applied, it would demonstrate that the skilled laborer and the typical doctor get roughly comparable hourly returns.

In a nationwide survey conducted recently among its 134,000 M.D.-readers, the average family doctor had a 1951 net income, before taxes, of $14,098. This bare figure doesn't take into account the extra hours the typical physician puts in.

The average family doctor's hourly base pay, assuming time-and-a-half for overtime and double-time for Sunday work, may be computed as follows:

According to our survey, the family doctor works an average of sixty-two hours a week. Twenty-two of these hours must be counted as overtime; perhaps five of these hours represent Sunday work. For pay purposes, therefore, he'd be credited with about seventy-five hours a week, or 3,750 a year . . .

The average family doctor nets $14,098 annually. Divide this figure by his hourly credits for the year (3,750) and you get the equivalent of hourly base pay. It turns out to be $3.76 an hour.

The interesting thing about this figure is its strong resemblance to current base pay for skilled union labor. Many bricklayers, for example, get $3.25 an hour nowadays. And if other workers earn less, and if medical specialists earn more, isn't this explainable in terms of *degree* of specialized skill?—*Medical Economics,* January, 1953.

PENSIONS TOO LOW, STUDY GROUP REPORTS

Although great progress has been made in providing pensions for the aged in the last fifteen years, a Congressional study group reported the average payments being made still are considerably below the subsistence level.

"The situation of the present aged is quite unsatisfactory," the report declared.

"Benefits are low, on the average considerably below subsistence except for those few, some 350,000, who are drawing pensions under both old-age and survivors insurance and private plans."

Present payments, the report went on, probably will be far too low to meet the living costs of the future.

The study forecast a national income of $600,000,000,000 annually in 1975, a vast increase in the millions of aged persons who must depend on pensions or other benefits, and warned of dangers in present systems.

The report came from the Senate-House Economic Committee, headed by Senator O'Mahoney (D., Wyo.), and resulted from a study two years ago of low-income families by Senators Sparkman (D., Ala.) and Flanders (R., Vt.).

It was prepared by the National Planning Association, a nonprofit, nonpolitical group headed by Robert M. Ball.

Most of the report and recommendations

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PENSIONS TOO LOW

(Continued from Page 130)

centered around the Old Age and Survivors Insurance program, which is part of the Federal Social Security program now covering 47,000,000 workers, or about eight of 10 employed.

Ball claimed general public acceptance of these principles:

1. An opportunity for continued work or productive capacity for aged persons, those who have passed 65 years or other age limits for pensions.

2. A public program "directed to income maintenance for the aged" over and above anything individuals or unions may arrange in the line of pensions or retirement benefits.

3. Gradual elimination of "a test of need" for the basic public program of assisting the aged.

4. Contributions by both workers and employers to the public program of pensions.

5. Acceptance of private pension plans as supplements to the public program.

The study said the average monthly benefit for a 65-year-old worker under OASI was $47, that for a married couple 65 or older $80 and that for an aged widow $40.

Although Congress has provided a higher benefit rate for the future, the study questioned that this will meet expected increases in living standards and costs.

The study said the aged group most greatly in need of assistance now includes widows, unable to take or get jobs, and permanently disabled who do not qualify for veterans, blind or similar assistance. —Press release, December 26, 1952.

TAFT TO TAKE CHAIRMANSHIP OF LABOR-WELFARE COMMITTEE

Senator Taft, announcing he plans to assume chairmanship of the important Labor and Public Welfare Committee, says that in the next Congress he will concentrate on social welfare problems rather than labor legislation. In the Republican-controlled Eightieth Congress Senator Taft also headed this committee, but divided his interest between social legislation and labor, including sponsorship of the Taft-Hartley law. In explaining his attitude, the Senator is quoted as saying:

"This time my interest is more in the public welfare end of the committee's work than in the labor end. General Eisenhower has spoken of expanding the social welfare program, and I am interested in seeing that the new legislation takes the proper course."

The Labor and Welfare Committee has handled a majority of bills important to medicine, including compulsory health insurance, aid to medical education, aid to local public health departments, drug prescriptions and some veterans bills.—*Washington News, AMA Capitol Clinic,* November 18, 1952.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

Mar. 10 MICHIGAN INDUSTRIAL HEALTH DAY Sheraton-Cadillac Hotel, Detroit

Mar. 11-13 MICHIGAN CLINICAL INSTITUTE Sheraton-Cadillac Hotel, Detroit

Mar. 13 Fourth MICHIGAN HEART DAY (part of MCI) Detroit

Spring MSMS Postgraduate Extramural Courses Statewide

April 8 Genesee County Medical Society Eighth Annual Cancer Day Flint

April Highland Park Physicians Club Clinic Highland Park

May 7 Ingham County Medical Society's Clinic Day Lansing

May 13 Wayne University Medical Alumni Clinic Day and Reunion Hotel Fort Shelby, Detroit

May 21 The American College of Surgeons Annual Symposium on Trauma and Nutrition Ann Arbor

June 1-5 AMA Annual Session New York

June 2 Annual Clinic Day, Bon Secours Hospital Detroit

June 19-20 Upper Peninsula Medical Society Annual Meeting Escanaba

July 30-31 Annual Coller-Penberthy Medical Surgical Conference Traverse City

August Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling

Sept. 22 Michigan Chapter, American College of Surgeons Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION Grand Rapids

Oct. 21 Michigan Cancer Conference East Lansing

Autumn MSMS Postgraduate Extramural Courses Statewide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

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R. L. Wade, M.D., Coldwater; Ralph Wadley, M.D., Lansing; R. W. Waggoner, M.D., Ann Arbor; Margaret E. Waide, M.D., Battle Creek; Josephine Wajert, M.D., Flint; E. M. Wakeman, M.D., Dearborn; Carver G. Walcott, M.D., Fenton; George L. Waldbott, M.D., Detroit; Enos G. Walker, M.D., Lakeland; Leo Whitney Walker, M.D., Lansing; Roger V. Walker, M.D., Detroit; C. H. Wallman, M.D., Alma; Arch Walls, M.D., Detroit; Floyd J. Walter, M.D., Detroit; John J. Walters, M.D., Battle Creek; Nell M. Ward, M.D., Flint; Frank E. Ware, M.D., Flint; David R. Wark, M.D., Flint; Woman's Auxiliary to Washtenaw County Medical Society; Donald F. Waterman, M.D., Grand Rapids; Thomas Y. Watson, M.D., Birmingham; Woman's Auxiliary to Wayne County Medical Society; Roy O. Webb, M.D., Okemos; John E. Webster, M.D., Detroit; Herbert S. Wedel, M.D., Hastings; Merle E. Wehner, M.D., Manistique; Garland Weidner, M.D., Saginaw; Harold R. Weidner, M.D., Coldwater; Frank A. Weiser, M.D., Detroit; Arno W. Weiss, M.D., Bad Axe; Jack I. Weiss, M.D., Huntington Woods; John M. Wellman, M.D., Lansing; Kenneth N. Wells, M.D., Spring Lake; Carl G. Wencke, M.D., Battle Creek; A. V. Wenger, M.D., Grand Rapids; John N. Wenger, M.D., Coopersville; John E. Wentworth, M.D., Flint; Inga Werness, M.D., Flint; H. O. Westervelt, M.D., Benton Harbor; Claude L. Weston, M.D., Owosso; Jean K. Weston, M.D., Detroit; Horace L. Weston, M.D., Detroit; Charles J. Westover, M.D., Plymouth; Warren K. Westrate, M.D., Holland; William Westrate, M.D., Holland; Russell F. Weyher, M.D., Detroit; Joseph L. Whelan, M.D., Detroit; Carl White, M.D., Fenton; Herbert T. White, M.D., Flint; Alec Whitley, M.D., St. Clair Shores; Elmer L. Whitney, M.D., Detroit; T. P. Wickliffe, M.D., Calumet; S. C. Wiersma, M.D., Muskegon; Fred K. Wietersen, M.D., Detroit; Ralph D. Wigent, M.D., Pontiac; Ira W. Wiggins, M.D., Jonesville; James W. Wilcox, M.D., Bay City; M. M. Wilde, M.D., Warren; Bernard C. Wildgen, M.D., Muskegon; Thomas Wilensky, M.D., Lansing; D. Bruce Wiley, M.D., Utica; Harold W. Wiley, M.D., Lansing; Carl A. Wilke, M.D., Montague; C. J. Williams, M.D., Detroit; John R. Williams, M.D., Grand Rapids; Howard R. Williams, M.D., Ann Arbor; William S. Williams, M.D., Grand Blanc; Thomas N. Willis, M.D., Flint; Clayton Willison, M.D., Sault Ste. Marie; C. O. Willits, M.D., Charlotte; Gordon L. Willoughby, M.D., Flint; Leslie L. Willoughby, M.D., Flint; Howard S. Willson, M.D., Lansing; C. Stuart Wilson, M.D., Detroit; Harry A. Wilson, M.D., Lansing; Norman D. Wilson, M.D., Jackson; Pitt S. Wilson, M.D., Muskegon; Walter H. Winchester, M.D., Flint; Sherwood B. Winslow, M.D., Battle Creek; John K. Winter, M.D., Holland; William G. Winter, M.D., Holland; George J. Winton, M.D., Detroit; H. C. Wissman, M.D., Detroit; R. A. C. Wollenberg, M.D., Detroit; George H. Wood, M.D., Onaway; M. G. Wood, M.D., Hart; J. J. Woods, M.D., Ypsilanti; M. H. Worth, M.D., Ann Arbor; Ralph Worthington, M.D., Lansing; Joseph J. Worzniak, M.D., Wyandotte; Harold F. Woughter, M.D., Flint; Donald R. Wright, M.D., Flint; Richard E. Wunsch, M.D., Detroit; John S. Wyman, M.D., Flint; George H. Wynn, M.D., Adrian; William C. Wyte, M.D., Mt. Clemens.

Gordon H. Yeo, M.D., Big Rapids; Stuart Yntema, M.D., Saginaw; Frederick F. Yonkman, M.D., Summit, N. J.; William J. Yott, M.D., Detroit; Arthur R. Young, M.D., Pontiac.

Daniel Zavela, M.D., East Detroit; Myron G. Zeis, M.D., Flint; Joseph L. Zemens, M.D., Detroit; Harry B. Zemmer, M.D., Lapeer; Victor M. Zerbi, M.D., Ypsilanti; A. L. Ziliak, M.D., Bay City; J. G. Zimmerman, M.D., Traverse City; Carl R. Zolliker, M.D., Imlay City.

When completed, DDT factory to be erected in Delhi, India, will be a World Health Organization training center for insecticide production. A joint project of the Indian Government, the U. N. Children's Emergency Fund and WHO, the plant is expected to be in full production by March 1954.

PR REPORT

Current Public Relation's Activities of MSMS

Adult Education

The Genesee County Medical Society in cooperation with the Flint adult education program has set up a series of six lecture-discussion courses on mental health for the coming semester.

This venture into the mental health education field was completed with the aid of A. C. Pfeifer, M.D., Mt. Morris, President of the Genesee County Medical Society.

The participating doctors of medicine and their subject matter include "Emotional Problems of Parent and Child," T. J. Lukens, M.D.; "Alcohol and Mental Health," Clayton K. Stroup, M.D.; "Psychosomatic Problems," Glenn E. Drewyer, M.D.; "Mental Problems Relating to Sex Education," Joseph Shapiro, M.D.; "Nervous and Mental Systems," Seymour L. Osher, M.D.; and "Problems of Aging," Paul H. Jordan, M.D.

* * *

Adult Education programs to date either have been presented or are in the process of being presented in a total of 14 Michigan communities under the sponsorship of 10 county medical societies.

The County Medical Societies represented with current or former programs are Bay, Genesee, Ingham, Jackson, Macomb, Marquette-Alger, Menominee, Oakland, St. Clair and Tuscola.

Other county medical societies are urged to begin an Adult Education series in their communities. Details on how to launch such a program in a locality can be obtained by contacting the MSMS Field Secretaries in your areas or by writing direct to the Michigan State Medical Society Public Relations Department in Lansing.

Latest Developments

Two new projects—a series of five-minute television shows and an exhibit—are now being prepared by the MSMS Public Relations Department.

1. The television shows will be filmed and packaged into 13-week units so that they can be used on any television station in Michigan. The programs will cover a variety of scientific and socio-economic topics. Doctors of medicine from all over the State will have an opportunity to participate in these programs.

2. The new exhibit will be unveiled at the Michigan Clinical Institute in Detroit, March 11-12-13, 1953. It will be available to county medical societies for use at fairs this summer and autumn.

More details on both of these new developments will appear on this page in a subsequent edition of THE JOURNAL.

Films Available

Motion pictures tell a story and sell ideas.

Three MSMS films are available to you to present the story of the medical profession in three important fields. You can use them in your Adult Education programs or screen them before service clubs and other organizations in your community.

The three films are "Lucky Junior," the story of immunization; "To Save Your Life," which tells how to become an M.D. and the costs involved; and "To Your Health," about compulsory health insurance.

You may obtain these interesting motion pictures by sending a request to the Michigan State Medical Society PR Department at Lansing.

"Medical Mailbox"

MSMS Television Program

WXYZ-TV (Channel 7), Detroit **Friday, 12:30 p.m.-1:00 p.m.**

Participant	*Topic*	*Date*
W. Z. Rundles, M.D., Flint	Clinical Use of the Audiometers in Industry	January 30
Martha L. Wells, M.D., Detroit	Proctology	February 6
John G. Bielawski, M.D., Detroit	Rheumatic Fever Control Program	February 13
E. I. Shumaker, M.D., Dearborn	Kidney Diseases	February 20
Harold J. Kullman, M.D., Detroit	Veteran Rehabilitation	February 27
E. S. Gurdjian, M.D., Detroit	Ruptured Discs and Their Surgical Care	March 6

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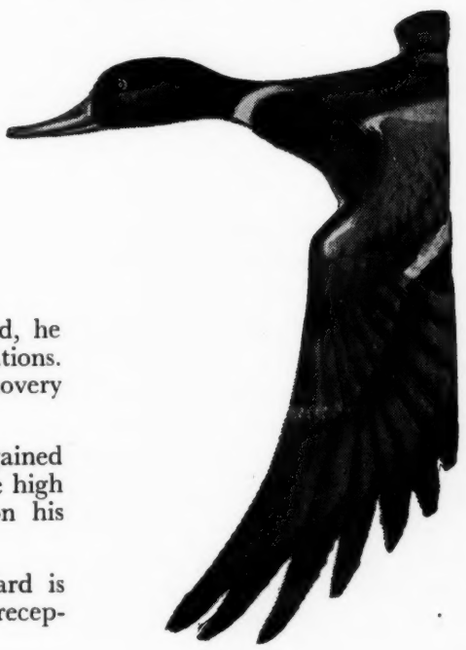
Leader . . . . . MALLARD, INC."



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one of the men responsible . . .

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Karl O. Mallard, President
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Ingham County Promotes Postgraduate Education

The Ingham County Medical Society will celebrate a silver anniversary in 1953. On April 26, 1928, the County Medical Society held its first Spring Clinic to which the medical profession of the State of Michigan was invited. Two hundred and twenty-seven doctors responded. As far as we can determine, this was the first clinic to be held in Michigan under the auspices of a county medical society.

Five years elapsed between the date of this first clinic and the second clinic held by the Ingham County Medical Society. Though the seed of the clinic idea was long in coming into bloom, germination of the idea was not so long delayed. The record shows that Drs. Milton Shaw and L. G. Christian proposed in 1931 that the Society hold an *annual* Spring Clinic. Successive clinics were held in 1933 and in 1935. From 1935 to the current date the Ingham County Medical Society has had a clinic day each year.

Although the actual date of the clinics has varied between late April and early May through passing years, custom has now fixed the date as the first Thursday in May and an increasing number of practitioners in Michigan mark this date as a "must" on their calendar.

The type of program also has varied from year to year. At various times the clinic has taken the form of a round table or a symposium on a particular subject. The most common and by far the most popular type of program has been one made up of four afternoon speakers and one after dinner speaker in which the subjects presented have covered widely different aspects of the practice of medicine. Although the subject matter presented in each clinic and from year to year has been varied, the general and specific objective has been the same throughout the years. The Ingham County Medical Society has proposed to bring to the average general practitioner of medicine current and practical information usable in his daily practice of the art and science of medicine.

Top-Notch Speakers Are Presented.—The list of speakers at the first clinic in 1928 included: W. C. Alvarez, J. C. Beck, J. T. Case, F. A. Coller, John Phillips, M. F. Porter and H. A. Reye. This list of distinguished gentlemen set the tempo for the caliber of speakers for succeeding meetings. Although speakers have been drawn from the entire geographic area of these United States and from England, the majority have come from the great reservoirs of medical teaching and practice in the Central States. Cleveland; Chicago; Rochester, Minnesota; Detroit and Ann Arbor vie statistically with each other for the honor of furnishing the greatest number of speakers. It has been interesting to note that the name of F. A. Coller appears three times in the records of the clinics and E. H. Rynearson twice. Nor can one help but stop and rejoice that we have been given the opportunity to bring to Michigan such individuals as the now immortal George Crile, Chevalier L. Jackson (Sr.), and W. T. Vaughan.

MILTON SHAW, M.D.

L. G. CHRISTIAN, M.D.

The quality of the speakers at the clinics and the suitability of the programs presented may be best attested by the record. The attendance at the first clinic was 227. In spite of an increasing number of sectional, regional and local meetings at this particular time of the year, the attendance has increased steadily from year to year except for the last war years. A review of registrations in the early clinics shows that practitioners came from as far east as Port Huron, as far west as Muskegon and Holland and as far north as Grayling and Gaylord. The geographic pattern of attendance has not changed through the years. The Ingham County Medical Society expects to see the same friends at each clinic and to make new ones also.

Many medical men already have reserved the first Thursday in May, 1953, for the twenty-fifth Anniversary Clinic of the Ingham County Medical Society.

Note—Some months ago the Editor asked County Medical Societies to prepare feature stories outlining some outstanding, or meritorious activity of the Society. We would be glad to feature some others. This story is a proud recital—EDITOR.

Cancer Comment

CO-ORDINATING FUNCTIONS OF THE CANCER CONTROL COMMITTEE

The magnitude of the cancer problem is apparent to physicians and laymen alike. Over the years a number of organizations have been formed to deal with some aspect of the challenge of malignancy. In Michigan four major organizations are active in this field. Two are professional in character and two are non-professional. The two non-professional groups are separate and co-ordinate divisions of the American Cancer Society. The American Cancer Society is a superb national group which has done much to bring the problems of cancer before the lay public, and by collecting large sums of money has made possible advances in research and treatment. The Southeastern Michigan Division of the American Cancer Society encompasses Macomb, Oakland, and Wayne counties which form metropolitan Detroit, while the Michigan Division represents the rest of the State. Each of these divisions has a number of prominent physicians on its board of directors, thus enabling these organizations to have competent and interested medical advice. The other two organizations interested in these endeavors are the State Department of Health and the Michigan State Medical Society. The emphasis of the activities of these two groups is mainly on the professional aspect of cancer control.

It is understandable that some sort of liaison should be maintained among these four groups. The Michigan State Medical Society is in a unique position in that the professional leaders and advisors of the other three groups are also members of the state medical society. The personnel of the Cancer Control Committee of the Michigan State Medical Society has been selected to represent all cancer groups in the State. The deliberations of the Cancer Control Committee should provide a common ground for the exchange of ideas and for promotion of knowledge on the part of its members of what the other fellow is doing. For example, the subcommittee of the state medical society on community cancer projects should be composed of physicians who are advisors to the community projects groups of the other three organizations. The advantage of this arrangement is self-evident. A major step along this line of co-ordination of activity has been the request by the State Health Commissioner for the formation of a special co-ordinating subcommittee of the Cancer Control Committee to act as advisors in the matters of cancer control being carried out by the State Health Department. This committee is composed of leaders in the other three organizations and will also act as advisor to all organizations requesting assistance.

The Michigan State Medical Society through its Cancer Control Committee cannot and will not become involved in the internal affairs of the other three organizations. However, it can be a source of advice in broad principles of policy, in integration of projects, and in the proper scheduling of endeavors.

Realizing that any cancer control program must function at the "grass roots" level, the Cancer Control Committee has endeavored to stimulate local co-operative action by distributing "The Role of the Cancer Committee of the County Medical Society in the Cancer Control Program" to all local medical societies, health departments and cancer units in Michigan. This short pamphlet points out the duties of each local group in any local cancer education or service program.

The Cancer Control Committee recently has made another contribution to cancer control in Michigan by distributing "The Story of Cancer For High Schools" to all public and parochial high schools in the state. This was a co-operative undertaking in that the Michigan Department of Health directly paid for most of the first printing of 5,000 copies. The local cancer units over the state distributed the manuals to each high school in their areas.

These are but two recent examples of co-operative effort at cancer control outlined earlier in this discussion. Many other similar opportunities doubtless will arise during the coming year.

The growing margin of a tumor provides the most dependable diagnostic picture.

* * *

As a rule, malignant tumors of infants and children progress rapidly and metastasize widely, recurrence is prompt and the mortality high.

* * *

Blue-black, green-black, or slate colored moles, are prone to become malignant.

* * *

Moles on the foot and in places exposed to constant irritation or chafing should be removed.

* * *

Operative removal of tumors of the central nervous system is the only possible treatment; however, results have been discouraging.

* * *

The common neoplasms seen in children logically fall into four groups; namely, malignant lymphomas, intracranial neoplasms, abdominal tumors, and primary malignant tumors of bone.

* * *

It is not so much the frequency of childhood cancer that is important but the risk to life involved if the disease is overlooked.

Heart Beats

FOURTH ANNUAL MICHIGAN HEART DAY PROGRAM

The Michigan Heart Association has planned another outstanding and diversified scientific program for presentation at its Fourth Annual Michigan Heart Day to be held in Detroit on Friday, March 13, 1953. Heart Day has been scheduled again this year in conjunction with the Michigan Clinical Institute (March 11-13) at the Sheraton Cadillac Hotel, Detroit.

The Heart Day program will offer a wide variety of reports covering investigations of various aspects of diseases of the cardiovascular system. This is another service to Michigan's Doctors of Medicine by the Michigan Heart Association through its continually expanding professional education program.

The Michigan Heart Association deeply appreciates the opportunity of providing this excellent program as an integral part of the Clinical Institute.

In keeping with an established and successful policy, three of the papers which will be presented at this meeting will be given by Michigan medical doctors who are carrying out research studies under the financial sponsorship of the Michigan Heart Association. Three other scientific papers will be presented by Doctors of Medicine from various sections of the United States.

The schedule for Heart Day and the speakers who will appear on the program is as follows:

9:00-9:20 a.m.

HAROLD B. HOUSER, M.D., Assistant Research Director, Weiting-Johnson Hospital, Syracuse, New York, will discuss the prophylaxis of rheumatic fever by prevention of or treatment of streptococcal infection. Dr. Houser was just recently separated from the Armed Forces where he served as a Major (MC) with the Streptococcal Disease Laboratory, Warren Air Force Base, Wyoming.

9:20-9:40 a.m.

HARPER K. HELLEMS, M.D., Wayne University College of Medicine, Detroit, will report on the extensive studies which he has carried out on the medical indications for mitral commissurotomy. Dr. Hellem's important work has been supported by a Michigan Heart Association research grant.

9:40-10:00 a.m.

F. D. DODRILL, M.D., Research Repartment of Harper Hospital, Detroit, will present a paper concerning some aspects of the mechanical heart-pump. The mechanical heart has been rated one of the top ten scientific developments of 1952. The Michigan Heart Association has provided financial support for this project since its inception.

10:00-11:00 a.m.

Intermission to view exhibits.

11:00-11:20 a.m.

EDWARD M. KLINE, M.D., Clinical Instructor of Internal Medicine, Western Reserve University, Cleveland, Ohio, will speak on the subject of "The Role of the Physician in the Employment of the Cardiac Worker." Dr. Kline is well known for this work in the field of industrial cardiology and is currently serving as Chairman of the Cardiovascular Section of the Industrial Medicine Association.

11:20-11:40 a.m.

ROBERT A. GERISCH, M.D., Harper Hospital, Detroit, will provide the latest developments on the use of ACTH and cortisone in the treatment of myocardial infarction. This research study has received nationwide prominence. The Michigan Heart Association is providing financial assistance to this project also.

11:40-12:00 m.

WILLIAM B. KOUNTZ, M.D., Assistant Professor of Clinical Medicine, Washington University, St. Louis, Missouri, will discuss "Heart Diseases of Mid-Life." Dr. Kountz is nationally known in the field of Geriatrics.

HENRY L. SMITH, M.D., Detroit, President-Elect of the Michigan Heart Association, will serve as Chairman of the Fourth Annual Heart Day.

E. D. SPALDING, M.D., Detroit, will be Leader of the Discussion Conference from 12:00 noon to 1:00 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel. All the Heart speakers have been invited to sit on the platform for this question period, always a highlight of the annual Michigan Heart Day.

DR. HENRY L. SMITH will be installed as the Association's fifth president at a meeting of the Board of Trustees which has been scheduled for 6:30 p.m. in the Founders' Room of the Sheraton-Cadillac Hotel. The annual meeting of members of the Michigan Heart Association will be held at 5:00 p.m. in Parlors G-H-I of the Sheraton-Cadillac immediately following the close of the Clinical Institute.

AMA News Notes

HOUSE ACTION ON FEDERAL MEDICAL SERVICES

After long debate, the AMA's House of Delegates adopted a resolution stating that the fundamental consideration of limiting the care of veterans in Veterans Administration hospitals to the two following categories is sound: (1) to veterans with peacetime or wartime service whose disabilities or disease are service-incurred or aggravated and (2) to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the necessary hospital expenses.

The resolution further comments that to discontinue the provision of medical care and hospitalization in VA hospitals for the remaining groups of veterans with non-service-connected disabilities cannot be accomplished without the co-operation of Congress, veterans organizations and the medical profession. The House of Delegates recommended that the AMA meet with representatives of veterans organizations, the American Hospital Association, American Dental Association, the Department of Defense, and the Veterans Administration to discuss problems and work out a satisfactory arrangement . . . rather than take action at the present time.

Other recommendations include: a definitive AMA policy on the subject of dependent medical care should be deferred until more study has been made; transferring of seriously disabled service personnel from service hospitals to VA installations should be continued; a clear congressional definition of the extent of government's responsibility for furnishing medical care to veterans with non-service-connected disabilities and dependents of service personnel should be obtained; a federal board should be established to allocate the number of beds required by the several federal hospital services to insure joint planning in the field of civilian and federal hospital construction and to determine the need and location for proposed new hospitals in the country.

AMA TO CONTINUE STUDY OF DOCTOR DRAFT LAW

The AMA's House of Delegates voted in December to "continue to support whatever measures are necessary to provide essential medical care to the armed services."

The House further authorized and directed the Board of Trustees and the Council on National Emergency Medical Service (1) to follow closely all developments both national and international which might affect the quantitative requirements for medical officers in the armed forces, and (2) to support legislation to provide the number of medical officers required to care adequately for the health needs of the uniformed armed forces.

The House recommended that the President of the United States be requested to defer any call-up of priority three physicians under Public Law 779 until the Selective Service System and the Department of Defense have completed processing all physicians in priorities one and two, except for physicians in those groups whose deferment is essential to the nation's health.

Careful study also is to be given in the ensuing months to—physical requirements for medical officers so that physicians with physical defects may be utilized; more effective recruitment methods for career personnel in military medicine; greater use of civilian physicians and hospital facilities in the care of both military and nonmilitary personnel and their dependents; uniform conditions of service to avoid undue competition for medical personnel, and consideration of an equitable point system in the induction of physicians into the armed services.

AMA ENCOURAGES "MEDICAL CARE FOR ALL" PROGRAMS

Medical societies were called upon to establish programs providing the services of a physician to anyone unable to pay for such services at the AMA's House of Delegates session in December. Since a number of county medical societies for several years have successfully maintained such programs, the House resolution urged the American Medical Association to encourage constituent state medical societies "to organize and vigorously promote similar campaigns embodying the principles of such programs." Medical societies were urged to publicize such programs "through every effective medium of communication."

AMA REVISES THE "ESSENTIALS OF AN APPROVED INTERNSHIP"

An Advisory Committee on Internship, appointed by the Council on Medical Education and Hospitals in the fall of 1951, conducted a study in the past year reviewing the internship in its broadest aspects. As a result of its study the Advisory Committee recommended revisions in the "Essentials of an Approved Internship" which were ratified by the AMA's House of Delegates in December.

Among the changes in the requirements for hospitals offering intern programs were the following: Approval by the Joint Commission on Accreditation of Hospitals; bed capacity increased to 150, excluding bassinets; annual admissions in-

(Continued on Page 160)

a broad spectrum dietary supplement

When anorexia interferes with the intake of needed foods in adequate amounts, the resultant effect on the nutritional status of the patient is considerably more apt to involve deficiency in several nutrients than in one particular nutrient. In consequence, unpredictable subclinical deficiency states may arise, which can seriously impede convalescence. Hence when anorexia is present, it is good prophylactic therapy to prescribe a dietary supplement of broad nutrient spectrum, capable of improving the intake of virtually all indispensable nutrients.

The dietary supplement Ovaltine in milk enjoys long-established usage in clinical practice. As is evident from the appended table, it supplies notable amounts of virtually all nutrients known to take part in metabolism. Its biologically complete protein provides an abundance of all the essential amino acids. It is delightfully palatable, easily digested, bland, and well tolerated.

Ovaltine is available in two varieties, plain and chocolate flavored, giving choice according to preference. Serving for serving, both varieties are virtually alike in their wealth of nutrients.

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Ovaltine

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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Editorial Comment

UNIONISM IN MEDICINE

This subject has been a standing joke in the medical profession for the last two years. Like most jibes, it has a sincere and deep-rooted basis in fact. Despite any humorous connotation there is here, the truth of the matter is that it needs to be stopped and stopped now.

When various academies and boards were organized, they were formed for the purpose of trying to improve all standards in a particular division of medicine. For example, the American Academy of General Practice was incorporated for the purpose of raising the level of practice of its members.

It is not, and never has been, the intent of these organizations to take on political connotations, but such powers as any group may wield must have some political meaning. This is a double-edged sword. Used for good, such influence may do much to improve standards. Used purely for political purposes, such powers are dangerous to medicine as a whole.

Never, in the basic thinking of the academies and boards has there been the slightest attempt to limit the practice of medicine to their own members. Yet, through the mistaken ideas of some more interested in money than in medicine, this has been done.

Many a large hospital is no more than a closed union shop where each worker must have a card to get a job at all. Rigid seniority is followed. The question is not "How good is the man?", but "How long has he been a member of the union and the shop?"

Jurisdictional disputes are common. The bone setter's union raises the very devil if a member of the child doser's union so much as looks at the child's broken finger. Forgotten completely is the basic objective of public service. Emphasis is on the mad scramble to keep up the union bars and see that no scab is allowed to work. Even undertones of collective bargaining are becoming apparent. With the closed shop, prices can be kept up and men who might be a bit critical of policy can be hushed up in a hurry.

Many medical organizations at the local level have begun to partake of all the worst features of labor unions without accepting the good features. There is nothing wrong with the labor union, but I will refuse to admit that a physician comes in the category of labor.

That the physician is essentially a laborer is the contention of those who would force regimentation upon us. There is no easier way to allow the advocates of socialized medicine to gain their ends than to play into their hands by behaving as lower bracket workers, rather than as professional men.

It is my contention that unionism is one of the finest things that has happened for the laborers of this country. It should be supported. But, unionism has no place in any public service or profession. If the doctor wishes to become a laborer, he has certainly started properly to achieve this end. Contrariwise, if we wish to maintain the dignity of a profession, then the only qualification for a man's advancement must be his integrity, diligence, and skill. All thoughts of the "closed shop" must be abandoned.—Paul Williamson, M.D., Editorial, *General Practitioner,* October, 1952.

EFFECTS OF BASIC SCIENCE LAWS

"The gates are wide open now. In 1940 there were 435 osteopaths registered in Michigan; in 1950 this has increased to 907, an increase of over 100 per cent in ten years, during which time the basic science law was in effect. Chiropractors registered in Michigan increased from 492 in 1940 to 747 in 1950, an increase of 50 per cent. There are some 11,000 osteopaths in the United States. On a population basis, we should have about 4 per cent of them. Actually we have between 8 and 9 per cent, and all this has come about with our basic science law in full effect. Does our law keep them out? Most definitely not. People will ask 'How do those of other schools get into the state, then?' A few come in by examination, most of them by reciprocity in basic science with Minnesota, Nebraska, and Arkansas—chiefly Minnesota. In 1949 Michigan issued 126 basic science certificates by reciprocity—only thirty-eight of these to medical doctors, the rest being to osteopaths, chiropractors, and unclassified. It must be granted that if our law were repealed we would probably have more than ever of the other schools for a short while. Soon, however, our state would secure enough medical doctors and the situation would take care of itself. Many people are cared for by non-medical men because there is no medical care available.

"States without basic science laws are not overloaded with those of other schools. Illinois has 12,795 medical doctors and less than 500 osteopaths. Ohio has 9883 medical doctors and less than 500 osteopaths. Neither state has a basic science law. When there is enough medical care available, the other types of practitioners fade away to a large extent.—Editorial, *The Pennsylvania Medical Journal,* September, 1952.

HEALTH INSURANCE PREMIUM WAIVER

Can the medical, hospital insurance policy holder be protected as to premium payments when he is unemployed or otherwise unable to meet his obligation?

It is being demonstrated daily that superior medical care can be delivered to the American people through the medium of the voluntary, prepaid plans, such as Blue Shield and Blue Cross. And, it is being done without resorting to mass care techniques, without dictation to the patient as to choice of doctor or without a waiting period for the decision of a bureau when a citizen wishes to "fire" his doctor or desires the services of a specialist. Both the patient and the doctor remain as free as thought, under our voluntary prepaid plans. And, the patient is pleased with the service he is getting and the way in which it is delivered to him. The steady increase in enrollment in the voluntary plan is the undeniable evidence of its success. This success is all the more remarkable because it has been achieved in spite of some justifiable worries that beset the policyholders. They worry about the day when unemployment may overtake them and protection is lost because the program, carried by the employer or the employe, lapses for non-payment of the premium or because the group advantage has become inoperative. They worry about being able to pay the premium when retirement comes; when income depends on a fixed pension or, worse still, on Social Security alone. And, such worries are well founded.

By paying a relatively small additional amount, it is possible to protect one's life insurance against periods of total disability—or it is possible to arrange premium payments in such a way that one need not pay beyond a stipulated number of years, e.g., a Twenty Pay Life policy. The premium of straight life insurance is great enough to build up cash values which automatically extend the protection, even after the policyholder discontinues payment.

We believe a careful exploratory study should be made to find out if the life insurance principle of protection can be applied to medical and hospital insurance policies so they can function when needed most by the policyholder—when he is out of money to buy his protection.—FRANK A. WEISER in *Detroit Medical News,* Nov. 3, 1952.

CABINET RANK FOR OVETA

When President-elect Eisenhower's Cabinet convenes after his inauguration, he has promised that Mrs. Oveta Culp Hobby will attend, although as the new Federal Security Administrator she will not have cabinet status.

Thus the importance of her post is recognized, although not officially. Perhaps it would be to the nation's advantage if Congress raised the Federal Security Agency to full cabinet rank.

Although comparatively new, the FSA is of major importance by the very nature of its many functions which closely touch the lives of every American citizen. The agency has more employes than either the State or Labor Departments.

Under Mrs. Hobby's jurisdiction will not only be Social Security, but the Food and Drug Administration, Office of Education and the Public Health Service. From the public standpoint, no department of the Federal Government is of more vital concern to the individual American or to the country's social progress.

Cabinet status for the Federal Security Administrator has been discussed before, but it is said that Congress was reluctant to act as long as the post was held by Oscar Ewing, the advocate of socialized medicine whose political philosophy had a leftward slant.

Mrs. Hobby, who will replace Ewing, promises to be a middle-of-the-road administrator with none of her predecessor's socialistic ideas.

With the FSA safely under her direction, Congress may be more favorably inclined toward giving her department equal footing with others of cabinet rank.—*Detroit Free Press,* December 8, 1952.

ARE WE WAITING FOR $5 BUTTER?

The point is well taken by the Northern Trust Company, of Chicago, that "the magnitude of the tax burden now is hardly realized by the great mass of the public." In spite of all the hullabaloo about high taxes, few persons even in low income groups are aware that about 20 per cent of their incomes are consumed by taxes. In the $3,000-$5,000 income group, taxes of all kinds take 25 to 30 per cent of incomes. The Chicago bank's October Business Comment observes that skimpy knowledge concerning taxes results from the method of the Federal income levy's collection ("for the most part (it is collected) before the pay envelope is received") and from "the difficulty in recognizing and adding up the multitude of hidden taxes."

Among those hidden taxes are, of course, the 8-cent Federal excise tax on cigarettes (the amount of which does not appear on the tax stamp itself); a 20 per cent levy on photographic materials; 10 per cent on television sets, radios and most household appliances; 15 per cent on fountain pens and mechanical pencils; 20 per cent on toilet preparations; 25 per cent on toll telegraph, telephone and radio messages, and 15 per cent on transportation. Excise and sales taxes now amount to between 15 and 20 per cent of total tax receipts, and siphon off approximately 8 per cent of incomes in the lower brackets. Another "hidden" tax is the corporate income levy, which by bringing in its wake higher prices, is estimated to absorb 5 per cent of lower bracket incomes.

Last year Federal taxes took about 24 per cent of the national income. This compares with 4.4 per cent in 1929. Primarily responsible for the phenomenal increase, as the Northern Trust Company

notes, is the nation's heavy expenditure for military goods. But what needs to be appreciated more keenly is that nonmilitary expenditures have grown much faster than national income. Nonmilitary expenditures in 1929 were only 1 per cent of the national income; today they amount to 7.3 per cent. The total of the two categories—military and nonmilitary—has reached a point at which the taxes themselves become inflationary.

It may be, as Harold Stonier, executive vice-president of the American Bankers' Association, observed the other day, that "people in general will not be bothered much about inflation (or high taxes, either) until it takes $5 to buy a pound of butter or a quart of milk or $50 for a pair of new shoes for their kids. . . ." Certain steps can be taken, however, to halt this upward trend. Responsibility for paying Federal income taxes needs to be placed back where it belongs, on the individual taxpayer, and the amount of excise taxes should be affixed plainly to those articles on which excises apply. These would be two concrete moves in the right direction.—Editorial, *The Richmond News Leader*, October 16, 1952.

ARMY EXAMINATIONS

I don't know why somebody doesn't give you a tip on what to wear for these Army examinations. I was running around stark naked, except for my hat, with my topcoat, suit, shirt, et cetera, all balanced on my right arm. Why didn't somebody tell me to leave my hat home and to wear a sweatshirt and overalls? The whole business would have been a bit annoying, if it hadn't been for the fact that everybody else looked so funny. Bald headed guys, fellows with scars all over them, fellows wearing hearing aids. One chap with a carcinoma of the tongue who had recently been operated on at Mayo's. In spite of yourself, you wonder if you look as bad as all these other guys do. Maybe these are the ones Truman meant when he spoke of the great number of physically unfit in this country. In any case, my hat's off to the tailors who can make fairly respectable looking people out of us middle-agers.

I think that the psychiatric examination was worth a comment. We stood in line in our birthday suits for a period of one-half hour waiting to see the psychiatrist. I didn't quite see the need of that particular attire, but I am not up on my psychiatry. It would have been more fair if the psychiatrist had been naked, too. Apparently, we all passed after we had answered satisfactorily the question of how we liked the Army. That one question constituted the interview. I believe that there were several acceptable answers to that question because we all passed. We were then allowed to put on our pants and groped our way up to the attic for our EKG. They had a little trouble with one unreasonable chap who had had a recent coronary and didn't care about climbing the stairs. They probably gave him an O.K. without the EKG. They were considerate about things like that. They paid one fellow's way clear over to Detroit twice to have rechecks on his chest x-rays. Of course, he had complete x-rays here for many years and had to give up a day's practice, but they couldn't take a chance on local x-ray reports.—President's Page, *Muskegon County Medical Bulletin*, November, 1952.

UNITED STATES STOCKOWNERS

About 6,500,000 individuals own publicly held stocks in this country, the Brookings Institution said today.

In a study entitled, "Share Ownership in the United States," the institution reported that the vast majority of the shareowners, or 76 per cent, earned less than $10,000 a year after taxes. The survey also showed:

More men than women were stockholders

Most persons bought stocks to make a profit

Persons in the 50-59 age group owned more stocks than other age groups

Share ownership was highest among administrative executives and college graduates

The study said that one out of every sixteen persons in the adult population owned shares in at least one stock issue, and that there were one or more share owners in every tenth family. The 6,500,000 stockholders are members of 4,750,000 family units.

There are 30,300,000 "shareholdings" in stock issues traded on organized stock exchanges and over-the-counter. Every individual holding counts as one shareholding. If a person owns shares in five stocks he has five shareholdings, therefore the number of shareholders is far less than the total of shareholdings. The number of shares in 16,655 stock issues classified as public-held is estimated at nearly 5,000,000,000.—*New York Times*, July 1, 1952.

SLOAN SEES END OF BIG FORTUNES

Board Chairman Alfred P. Sloan, Jr., of General Motors, says philanthropic foundations in the future will have to be financed by business or government.

Private individuals can't do the job that Henry Ford, John D. Rockefeller, Andrew Carnegie and others once did, Sloan said, because high taxes and living costs make it impossible for them to "amass great fortunes." Sloan, testifying before a house committee trying to determine whether any tax-exempt foundations have supported subversive activities, said his own case shows the great fortunes are gone forever.

He set up the $30,000,000 Sloan foundation in 1934, he said, but "I pay an 88 per cent income

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Meat...

and the Therapeutic Value of Adequate Protein

Much evidence can be cited in favor of a high protein intake after surgery, trauma, infection, or burns. In supporting the many anabolic and defense mechanisms of the organism in physiologic stress,[1] high-quality protein—such as that of meat—assumes the status of an important therapeutic agent.[2]

Phagocytic activity,[3] formation of antibodies,[4] and rapid healing of wounds[5] are favorably affected by ample protein nutrition. Remission of peptic ulcer,[6] improved resistance to infectious disease,[4] and maintenance of plasma proteins after surgery[7] are other therapeutic effects attributed to an ample protein intake. In the management of ulcerative colitis, protein represents a primary need.[8] Recent advances in the treatment of extensive burns and of hepatic disease emphasize the value of high protein feedings.[9]

These experimental and clinical findings establish the therapeutic value of high protein intake.[10] To assure therapeutic protein adequacy, the dietary should provide a liberal margin of protein over normal requirements.

Meat is an important source of high-quality protein, containing essential as well as nonessential amino acids. In addition, it supplies significant amounts of B group vitamins and of iron, phosphorus, and other needed minerals.

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American Meat Institute
Main Office, Chicago...Members Throughout the United States

SLOAN SEES END OF BIG FORTUNES

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tax now. I don't have enough left to invest in a foundation."

Asked if he knew of any foundation financing attempts to "weaken or undermine" the free enterprise system, Sloan said, "I have no reservation in saying they serve to strengthen the economic system."

"There may be something of the other kind present," he said, "but by and large they have tended to strengthen the American system."

Sloan said he hopes business, rather than industry, will take over the financing of philanthropic foundations because "government can never perform a business activity of this kind as well as an individual. A foundation financed by private funds can exercise more imagination and initiative."—United Press release, Dec. 12, 1952.

"A HEALTHY DEATH"

In a recent issue of the *Floyd* (Va.) *Press,* our attention was attracted by the above caption in the editorial column. The subject matter is so apropos and so well expressed that we quote the entire editorial:

> "Two or three years ago, it will be recalled, federal compulsory health insurance was a red hot issue. The whole weight of administration pressure was thrown behind it, regiments of propagandists in interested government bureaus were grinding out reams of encomiums in its behalf, and there seemed to be a fair chance that Congress would pass the proposed bill or some modified version thereof.
>
> "Today, this cure-all scheme isn't exactly dead, but it is certainly moribund. Administration spokesmen have pretty well run out of wind so far as it is concerned. The Republican Party has adopted a campaign plank strongly condemning it and the Democratic Party's plank ignores it. Neither of the candidates has shown any taste for it.
>
> "That's one healthy death for the nation."

We trust Brother Hallman is correct in his estimate of the situation, but we would like to see each candidate for the presidency speak out frankly against this socialistic proposal. At any rate, we agree that the death of this issue would really be a healthy death for the nation.—Editorial, *The West Virginia Medical Journal,* November, 1952.

SPEAKING OF TAXES

The report of the American Medical Association's "Special Committee on Federal Medical Services" could not have come at a more opportune time. Millions of Americans are looking forward to reductions in federal expenditures—and federal taxes—as a result of the recent Republican victory. In Washington, Mr. Eisenhower's chosen experts are examining budget figures in an effort to determine where savings can be made.

It seems providential, therefore, that the AMA special committee has just now completed its yearlong study which, if approved and adopted, could save hundreds of millions of dollars annually in Veterans Administration medical costs.

Most of us think of VA hospitals, such as the huge, new hospital in Denver, as institutions for the care of veterans who are ill or disabled because of diseases or injuries suffered as a result of their military service.

The AMA committee notes that the American people are almost unanimously in favor of free federal hospital and medical care for such veterans. However, the committee discovered that in 1951, 432,995 patients, 84.6 per cent of all patients discharged from VA hospitals that year, were not veterans of that kind.

Instead, they were veterans who were in VA hospitals because of diseases or injuries incurred after they had returned to civilian life. In other words, the VA hospital and medical service which is now costing taxpayers about $600 million a year is not being conducted primarily to take care of war "victims."

The AMA committee does not believe that a civilian whose leg is broken in an automobile accident is entitled to have it fixed at federal expense merely because he was a GI at some time in the past.

With the AMA committee view, most Americans will heartily agree, we believe.

Theoretically, veterans who receive free treatment for illnesses and disabilities not connected with their war service are supposed to be men or women who are "needy."

The nonservice-connected patients sign statements that they are unable to pay for the care they are seeking free from the VA. Actually, everyone admits the statements of need are meaningless. The VA has taken the position that it cannot question the need of a patient if he is willing to sign the statement.

In bona fide cases of need, cities and counties are prepared to furnish free hospitalization and medical care. It is impossible to escape the conclusion that free care by the VA for veterans with nonservice-connected illnesses has become a nationwide racket.

The AMA committee would continue free VA care in the case of service-connected disease and disability. It also would continue free VA care for nonservice-connected veterans who are in real need if those veterans are suffering from tuberculosis or psychiatric or neurological disorders.

Beyond that the AMA committee would not go. It warns that already there are approximately 20 million veterans in the country and that the number is increasing by about one million a year.

No time should be lost in cutting down the free patient load of the VA and in ending a scandalous expense that taxpayers cannot afford.—*The Denver Post.*

EDITOR'S NOTE: Two days after this appeared, Admiral Boon was given the floor of the House and talked the representatives into a delaying, washed-out stand.

SELF-DISCIPLINE

In medicine, we are banded together primarily for wider and fuller dissemination of scientific information that we may better serve our fellow men. We are self-disciplined by a code of ethics and professional behavior more stringent than is subscribed to by any other group in modern society. We are disciplined further by years of training in attitudes of inquiry and examination of facts which will ever be the safeguards of scientific progress. We are more critical of ourselves than those who would destroy us can ever be in their efforts to discredit us—and all to the end that each physician as an individual may grow in knowledge and professional stature and thus improve the quality of medical care which he can render.—WILLIAM A. LIGGETT, M.D., in *Rocky Mountain Medical Journal,* December, 1952

GOVERNMENT BY TREATY

The Constitution of the United States, in one sense, provides for its own destruction. Article VI, paragraph 2, is as follows:

"This Constitution, and the laws of the United States which shall be made in pursuance thereof; and ALL TREATIES MADE, OR WHICH SHALL BE MADE (capitalization ours) under the authority of the United States, shall be the supreme law of the land; and the judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding."

When a treaty passes from the executive branch of the government to the Senate there is little fanfare unless it be of such general public interest that it has been discussed at some length in the press. The Senate may ratify a treaty by a two-thirds vote of members present and voting, providing only that a quorum be present. One can easily discern from this the ease with which constitutional changes can be made. These changes may not follow the original intent of the men who framed our Constitution, yet they become the supreme law of the United States and of each and every state.

The United States is one of the nations which ratified the United Nations charter, thus making it a part of international law. The United Nations has ramifications about which the average citizen knows nothing. For instance, the International Labor Organization is an integral part of the UN. Reference to an editorial in the September issue of the Journal will show how the latest "convention" (treaty) framed by this organization can result in the ultimate in socialized medicine providing only that our Senate ratifies this convention. It has been said on good authority that approximately twenty of these apparently(!) minor treaties are awaiting our next congress. The ILO "convention" is probably amongst them. One might assume that certain elements of our population have selected this method of gradual and piecemeal destruction of our Constitution.

When a bill comes before Congress by the usual method it becomes a matter of public knowledge. Physicians, lawyers, and Mr. Average Citizen may easily ascertain what such a law holds in store in relation to his life and work. The citizen has a good chance of preventing legislation that he believes detrimental to him or the people at large. It is not so in the case of the treaties such as we are discussing. Here we must depend upon the watchfulness and integrity of our friends in the Senate.

The writer has a letter from the Italian Ambassador addressed to the Bureau of Examining Boards of Nebraska under date of October 29, 1952. It shows one sorry result of the "Treaty of Friendship, Commerce and Navigation" between the United States and Italy, signed in February, 1948. Unfortunately space prevents quoting the whole letter but we shall try to summarize the important points.

The letter points out that the treaty established that "the nationals of either High Contracting Party be permitted to exercise commercial, manufacturing, processing, financial, scientific, educational, religious, philanthropic and professional activities, except the practice of law."

When the Italian Embassy asked the Department of State for its interpretation in relation to the practice of medicine and dentistry, the following opinion was given: "The treaty provisions would require the States, each according to its own procedure, to admit Italian nationals to the practice of medicine on terms as favorable as those on which each admits its own citizens . . . Such treaty rights would be enforcible by Italian nations in the State and Federal courts of justice. State laws or regulations forbidding aliens to practice medicine, or providing conditions more burdensome than for the State's own citizens, would be inoperative with respect to Italian nationals . . ."

The letter ends with a polite request that the following questions be answered:

"1. Aside from the question of the recognition of academic titles, are there in your State laws or regulations forbidding foreigners to practice medicine or dentistry?

"2. If so, WHAT STEPS HAVE BEEN TAKEN TO RENDER INOPERATIVE SUCH LAWS AND REGULATIONS with respect to Italian nationals? (caps ours).

"3. What procedure should an Italian citizen follow to obtain recognition in your State of the specific treaty rights which put him in the same position of a national of the United States in regard to the condition of citizenship, when applying for the exercise of medicine or dentistry?"

This treaty clearly demonstrates the effect upon our Constitution and upon the rights of the State which may result from GOVERNMENT BY TREATY. A constitutional amendment will be

introduced in the next Congress to prevent such legislation by treaty. Every physician should support this amendment in every possible way. Such an amendment may take several years for ratification. In the interim, we should each urge his Senator to be ever watchful in preventing the ratification of treaties which tend to destroy our Constitution and to ignore the rights of the State. —Editorial, *Nebraska S.M.J.*, December, 1952.

"HOW SICK IS SOCIALIZED MEDICINE?"

It has been aptly said that "our fight is against the malignancy of Socialism, not merely socialized medicine," if the free world is to survive. Since malignancy is defined not alone as the quality of being malignant, virulent or life-threatening but also as a tendency to increase in virulence, certainly socialized medicine in practice offers a timely example of socialism's progressively virulent nature. What impartial observer can gainsay that it is truly malignant in that it tends to go from bad to worse?

A recent survey of Britain's national health scheme by Melchoir Palyi, noted economist, reveals its result as the depressing opposite of its glowing promises. Less than three years after the program became law in Britain, 553,577 persons were on the waiting list for hospital beds. Many of the mentally deficient and the helpless aged have been deprived of institutional care and are left to shift for themselves. In four years, the costs of governmentalized medicine have almost trebled, mounting to more than 10 per cent of the overinflated national budget.

The something-for-nothing Utopia, advertised worldwide, is now in slow retreat. Socialism or no socialism, the people are finding that they actually pay for what they get "free." "First class" treatment is open primarily to those who can afford to pay. It seems astounding from the sheer physical feat involved, let alone the professional aspects, that fewer than 20,000 general practitioners carry the main burden of medical care for more than 45,000,000 people. In industrial medicine there is no progress at all.

"How Sick Is Socialized Medicine?" This title of Mr. Palyi's excellent magazine article† is a timely question worthy of careful consideration. Physicians and laity alike need to be well informed on the subject. Britain's health program offers a notable example of the malignancy of socialism and affords an excellent illustration of the pitfalls which await this country if it continues its disastrous socialistic trend.—Editorial, *Journal Florida Medical Association,* December, 1952.

† Palyi; M.: How Sick Is Socialized Medicine? The Freeman (June 16) 1952. Reprints at $7 a hundred or $60 a thousand may be obtained from The Freeman, Dept. PB, 240 Madison Ave., New York 16, N. Y.

AMA REVISES THE ESSENTIALS OF AN APPROVED INTERNSHIP

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creased to 5,000, exclusive of the newborn, and the autopsy rate increased to 25 per cent.

Under these revisions the Council will approve rotating and mixed internships and straight internships in these specialties—internal medicine, pediatrics and surgery. Straight internships in pathology and obstetrics-gynecology will no longer be approved.

The revised "Essentials" became effective January 1, for new approvals. The autopsy rate of 25 per cent became effective for all hospitals January 1.

AMEF '52 FUNDS TOTAL MORE THAN $886,430

Contributions to the American Medical Education Foundation in 1952 totaled more than $886,430. This includes an American Medical Association grant of $500,000 voted by the House of Delegates in December, 1951, at Los Angeles. In all 6,739 contributions have been recorded from 6,697 individuals, eleven laymen and thirty-one organizations.

Distribution of Class A grants for the seventy-nine medical schools in the country was made in August . . . $15,000 for each of the seventy-two four-year schools; $7,500 for each of the six two-year schools, and $11,250 for one three-year school.

Particularly encouraging . . . contributors up 4,863 over 1951 . . . total receipts up $140,513 over 1951.

POINT IV AGENCY SEEKING PUBLIC HEALTH PHYSICIANS FOR TWELVE COUNTRIES

Because of stepped up Point IV operations, the Technical Co-operation Administration says it urgently needs twenty-four public health physicians for assignments in Burma, Iran, Jordan, Saudi Arabia, Bolivia, Chile, Colombia, Costa Rica, Ecuador, Honduras, Nicaragua and Panama. Twenty-nine U. S. physicians are now working on TCA health and sanitation projects in more than thirty countries.

An agency spokesman said posts of deputy chief, health and sanitation staff, are available in Burma, Jordan and Saudi Arabia, and seven chiefs of regional offices are open in Iran. Salaries range from $10,000 to $15,000 a year, including allowances.

Dr. H. van Zile Hyde, director of health and sanitation staff for TCA, left Washington recently for Geneva where he was to be joined by a World Health Organization representative. The two will tour Near East countries in an effort to bring about better co-ordination between WHO and TCA health programs.

Military Medicine

MEDICAL EDUCATION FOR DEFENSE PROGRAM TO BE CONTINUED IN 1953-54

The Medical Education for National Defense (MEND) program will continue during the 1953-54 academic year on a broadened scale in selected medical schools, Colonel Floyd L. Wergeland, MC, Chief of the Education and Training Division in the Office of the Army Surgeon General, reported. Colonel Wergeland spoke before a combined meeting of Philadelphia area Medical Reserve units.

Five medical schools are conducting the program during the current academic year on an experimental basis in co-operation with the Defense Department and other Federal agencies. Colonel Wergeland said both the faculty and students of participating schools had co-operated enthusiastically in the effort to incorporate military and civil defense aspects of medical subjects into the regular curricula of these institutions.

The schools selected by the Association of American Medical Colleges for the pilot study were the University of California, the University of Illinois, the University of Buffalo, Cornell University and Vanderbilt University. Other colleges of medicine will be added to the list as the success of the initial experiment is fully established and norms for the operation of the plan are worked out.

The MEND program provides that subjects related to military medicine and disaster relief be introduced into as many first-year medical courses as possible.

The program had its beginning on June 24, 1950, when the Committee on Preparedness for War, meeting in Chicago with the Executive Council of the Association of American Medical Colleges, appointed a joint Committee on Medical Education in Time of National Emergency.

The joint committee is composed of representatives of the Association of American Medical Colleges, the Council on Medical Education and Hospitals of the AMA and representatives of Federal medical services.

The committee concluded that the Medical ROTC program was not a suitable vehicle for the required curriculum changes. It declared a new type program should be adopted after studies had been made in several medical schools. Thus the present pilot studies in the five universities came into being.

It was agreed that the primary emphasis in the program should be on areas of fundamental importance to military medicine and civil defense. The plan included orientation of medical faculties in these areas.

Defense Department permission was obtained to substitute the new program for that prescribed by ROTC for first-year medical and dental students during the academic year 1952-53.

One anticipated result of the program is an increased sense of civic responsibility on the part of medical school graduates according to Colonel Wergeland.

ARMY INVESTIGATES SOCIAL RELATIONSHIPS IN COMBAT

Group relationships which reduce psychological stress, combat fatigue, and neuropsychiatric breakdowns of American soldiers are being studied in Korea by the Army Medical Service.

Under the title of "A Study of Social Strengths in Combat Units" the relationships of the combat soldier to his social situation, social structure, and culture are being investigated. The project, already under way, is under the joint sponsorship of the Neuropsychiatry Division of the Army Medcal Service Graduate School, and Michigan State College.

The three-months on-the-spot study of the formal and informal social system of a rifle company in combat is being made by Capt. Roger W. Little, MSC, a World War II Infantry veteran of the European-African-Mediterranean campaigns. He received the Bronze Star for valor, and a Purple Heart for wounds received in action.

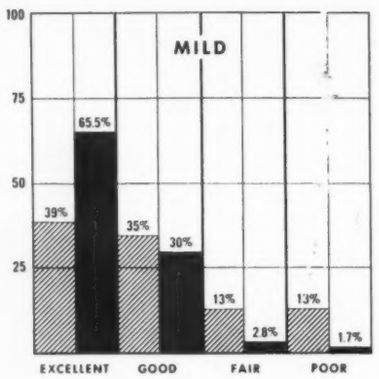
Captain Little received his A.B. degree in Sociology at Harvard in 1948, and his Master's degree in Social Casework at the University of Chicago in 1949.

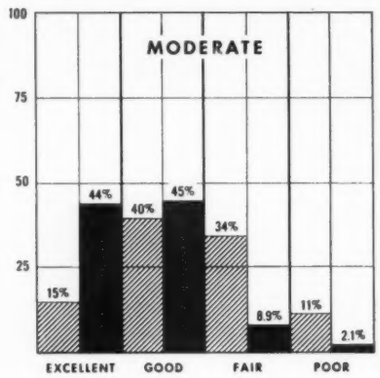
MEDICAL ECONOMICS

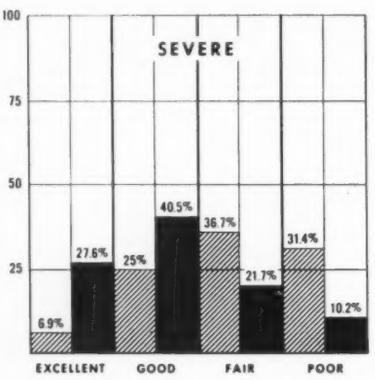
Oranges, grapefruit, peas, olives, walnuts and tumors are of various size. In the interest of precise verbal description, therefore, it would seem to be a good suggestion that physicians familiarize themselves with the language of green-grocers in order that they may state the size of a tumor with an exactness becoming to fellows of science.

The less than precious description, "the size of a grapefruit," then would give way to the eminently more precise "the size of a two-for-a-quarter grapefruit." Thenceforth, readers of medical literature who kept themselves reasonably well informed upon conditions in the citrus fruit market would have little difficulty in determining an author's meaning. To them, it would be but child's play to calculate that, at today's prices, the tumor was, to put it in their own simple words, 10 cm. in diameter.

Since rising commodity prices must, in this order of things, make two-for-a-quarter tumors smaller and smaller, it is conceivable in the newer economic thinking of our day that tumors might somehow be inflated out of existence.—*California Medicine.*







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Graphs reproduced from *Diabetes*, *1*:4, p. 293.

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The JOURNAL

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The Doctor William Beaumont Memorial on Mackinac Island

Alfred H. Whittaker, M.D.

Chairman, MSMS Beaumont Memorial Restoration Committee

Detroit

THE William Beaumont story is long familiar not only to doctors, but to school children. It is the story of a young surgeon's mate stationed in a wilderness outpost who took advantage of an accident and made one of the greatest contributions to scientific medicine; a discovery which resulted in great benefit to all mankind.

Through an accidental injury to a French Canadian Voyageur, Dr. Beaumont was able to study the interior of a human stomach, and, by a carefully observed series of experiments, to establish knowledge of the digestive processes of the gastrointestinal tract.

In large medical centers, where clinical and laboratory facilities were available, history records other cases of gastric fistula, but the knowledge of digestion continued theoretical, being attributed to the warmth of the body and resulting putrefaction, fermentation, and the mechanical (maceration) action of the stomach wall.

Dr. Beaumont, the pioneer physiologist of the United States and the first to make a contribution of enduring value, settled finally the chemical nature of the digestive process so much discussed from the days of the fundamental experiments of Reaumur* (1752) and Spallanzani** (1782). In the absence of any facilities and working entirely alone, Dr. Beaumont's scientific methods were excellent.

Medicine prior to Beaumont had recorded few who were able to observe accurately their findings. Theophrastus Bombastus von Hohenheim (Paracelsus)† and later Vesalius,‡ had this ability and established the true scientific methods of research, but on this continent it was not until June 6, 1822, that destiny let fall in the path of this young medical officer the opportunity which he recognized, grasped, and improved with a zeal and unselfishness not exceeded in the annals of medical science.

William Beaumont, fourth in descent from William Beaumont who came to America from England about 1635, and settled in Saybrook, Connecticut, was born at Lebanon, Connecticut, on November 21, 1785. He received the usual public school education and by the turn of the century he was fifteen, at a time when John Adams had just completed his administration. Thomas Jefferson had succeeded to the presidency. His administration was ushered in with evidence of the great

*Rene Antoine Ferchault de Reaumur, 1683-1757, French natural philosopher and inventor of the Thermometer.

**Lazaro Spallanzani, 1729-1799, Italian anatomist.

†Theophrastus Bombastus von Hohenheim, 1493-1541, a Swiss alchemist and physician. He was known as Philippus Aureolus Paracelsus.

‡Andreas Vesalius, 1514-1564, Belgium anatomist in Italy.

THE COVER

The "Beaumont and St. Martin" painting by Dean Cornwell was presented by Wyeth Incorporated of Philadelphia, to the Michigan State Medical Society at its Annual Session in Detroit, September 23, 1952. The painting is now housed at 606 Townsend, the "home" of the Michigan State Medical Society. Eventually, it will be given a place of honor in the Beaumont Memorial at Mackinac Island when erected. The four color plates used on the cover of this Number of THE JOURNAL were supplied through the courtesy of Wyeth Incorporated.

progress that the country was making. Jefferson's second administration witnessed the beginning of the aggression of England's navy on American commerce, and the seeds of the War of 1812, in which Beaumont was to take an important part, had already been sown.

Prompted by a feeling of restless ambition, which was to characterize his future life, Beaumont left his father's home in 1806. Traveling with a horse and cutter, a barrel of cider, and $100, he arrived in the spring of 1807 at the little village of Champlain, New York, which was only a few miles from the Canadian Border. Having been trained in one of the best of the New England public schools, he asked of the trustees a position as teacher, was accepted, and continued successfully in this capacity for three years.

While going north to Champlain by way of Western Vermont, Beaumont came in contact with Dr. John Pomeroy, a prominent physician and surgeon in Burlington, from whom he borrowed such books as would give him the fundamentals of medicine. While teaching school and tending store in Champlain he found time to read these medical works, using his years of teaching to accumulate sufficient money to keep him through the prescribed two years of medical apprenticeship.

In the fall of 1810, he crossed Lake Champlain to St. Albans, Vermont, where Dr. Benjamin Chandler was a capable practitioner. Dr. Chandler accepted young Beaumont, taking him into his home as an apprentice, and came to exert an excellent influence on the mind of his assistant, emphasizing the importance of a good memory, and of developing his power of observation and the habit of logical thought.

On June 2, 1812, Beaumont was granted a license to practice, his diploma being signed by the Dr. Pomeroy who had earlier loaned him medical books. After being granted his license to practice, he remained with his preceptor until September 8. War having been declared with Great Britain, he left Vermont for Plattsburg, New York, where on September 13, 1812, he was received into the army as surgeon's mate and assigned to the Sixth Infantry Regiment on brevet from General James Bloomfield. His commission was issued by President James Madison in December, 1812.

Dr. Beaumont experienced a very active participation in numerous engagements, recording many cases which are of interest to the military surgeon and the surgeon of trauma.

The treaty of Ghent was signed in December, 1814, and ratified in February, 1815, putting an end to hostilities. A few months later, Dr. Beaumont tendered his resignation and entered practice in Plattsburg, where he had many friends and a deserved reputation. Practicing until 1819 his work was characterized by careful observation and records.

Active service in the medical corps having become more attractive in the meantime, Dr. Beaumont on March 18, 1820, was commissioned post surgeon of the United States Army by President James Monroe, to take rank from December 4, 1819. He was immediately ordered to Fort Mackinac on the northern frontier, where he was to report to General Alexander Macomb under whom he had served valiantly in the battle of Plattsburg.

Mackinac had become the center of a series of trading posts established in a large territory including the shores of Lake Michigan, Lake Huron, Lake Superior, and the Mississippi country. In the fall brigades of several bateaux, each manned by a clerk and five to eight voyageurs, started for their distant stations. The voyageurs, like the *coureurs des bois,* formed a sort of fraternity which had gradually developed through the demands of the fur trade. They were French Canadian, sprung from the habitant class, but differed in that they were of a roving disposition, at home only on the water. About three thousand of these lighthearted fellows were in the employ of the American Fur Company.

Early in June, 1822, Indians and voyageurs were returning to Mackinac with the results of their winter efforts. The little village had awakened from its long sleep, and the beach was again crowded with tents and wigwams and a seething mass of strange humanity. Many of the returning voyageurs crowded into the retail store of the American Fur Company in order to buy buckskin coats, moccasins, flannel shirts, and gaudy neck bands.

It was in this little throng that a tragedy occurred on June 6, 1822. This was to leave its imprint on the pages of medical history for all time to come. As described by Jesse S. Myer,[1] the biographer of Beaumont, a gun was accidentally

discharged and Alexis St. Martin, a young voyageur, dropped to the floor with a cavity in the left upper abdomen that would have admitted a man's fist. He proved to be a young French Canadian about nineteen years of age who had recently come down from Montreal.

Gurdon S. Hubbard was an eye witness of the accident and the only one who was careful enough to leave any statement concerning the affair. He reported as follows:

"The late Major John H. Kinzie had charge of the American Fur Company's retail store at Michilimackinac. I was in the habit of assisting him occasionally when a press of customers needed extra clerks. The store comprised the ground floor near the foot of Fort Hill, on the corner of the street and the road leading up to the fort. The rear part of the store was underground, built of stone, which is still standing. This St. Martin was at the time one of the American Fur Company's engagees, who, with quite a number of others, was in the store. One of the party was holding a shotgun (not a musket), which was accidentally discharged, the whole charge entering St. Martin's body. The muzzle was not over three feet from him—I think not over two. The wadding entered, as well as pieces of his clothing; his shirt took fire; he fell, as we supposed, dead.

"Dr. Beaumont, the surgeon of the fort, was immediately sent for, and reached the wounded man within a very short time—probably three minutes. We had just got him on a cot and were taking off some of his clothing.

"After Dr. Beaumont had extracted part of the shot, pieces of clothing, and dressed his wound carefully, Robert Stewart and others assisting, he left him, remarking, 'The man can't live thirty-six hours; I will come to see him by and by.' In two or three hours he visited him again, expressing surprise at finding him doing better than he anticipated. The next day, I think, he resolved on a course of treatment, and brought down his instruments, getting out more shot and clothing, cutting off ragged ends of the wound, and made frequent visits, seeming very much interested, informing Mr. Stewart in my presence that he thought he could save him.

"As soon as the man could be moved he was taken to the fort hospital, where Dr. Beaumont could give him better attention. About this time, if I am not greatly mistaken, the doctor announced that he was treating his patient with a view of experimenting on his stomach, being satisfied of his recovery. You know the result.

"I knew Dr. Beaumont very well. The experiment of introducing food into the stomach through the orifice, purposely kept open and healed with that object, was conceived by the doctor very soon after the first examination."

Dr. Beaumont has also left an account of the examination of St. Martin and his subsequent care in the fort hospital. Although every effort was made to close the opening in the stomach, the aperture persisted. During the ensuing two years the series of experiments previously alluded to were carefully planned and carried out, providing observations and material which was sent to chemists and other clinical workers as far away as Edinburgh.

In the fall of 1824 Beaumont sent a complete report of Alexis St. Martin's case to Surgeon-General Joseph Lovell for his approval and correction with the suggestion it be published in some reputable medical journal. The article appeared in the *Medical Recorder* early in 1825, but through an oversight on the part of someone, it was published as "A Case of Wounded Stomach," by Joseph Lovell, Surgeon-General, U.S.A. The mistake was corrected, however, and credit was given to Beaumont. In 1833 the experiments were published in detail.

Several papers giving the story of Beaumont and Alexis St. Martin appeared over the years but it was not until 1912 that a full history was published when Dr. Jesse S. Myer produced his *Life and Letters of Dr. Wm. Beaumont.* Dr. Myer had been given the contents of two old chests by the daughter of Dr. Beaumont, Mrs. Sarah Beaumont Keim, who lived in St. Louis where her father practiced during the last twenty years of his life. The chests contained documents, manuscripts, memoranda, diaries, letters, clippings, and books. From Dr. Myer's biography of Beaumont much of this account has been obtained.

Several centers of Beaumont interest have been developed in this country. The chief of these will be the old retail store of the American Fur Company of Mackinac Island when its restoration is completed. The store is to be recreated from the lower part of the building, which still stands. The working drawings are completed, and the property purchased by the Michigan State Medical Society. When the building is restored during the summer of 1953, it will be given to the Mackinac Island State Park Commission to be preserved by the state of Michigan as the country's most significant medical shrine.

For the medical men of the future and for the people of the North American continent, there will thus be preserved the memory of the surgeon who discovered the nature of gastric digestion by

his keen powers of observation. This contribution of Dr. Beaumont has been of benefit to all mankind. He, by his skillful treatment, helped in the recovery of a seriously injured person, and thus was enabled to perform a carefully recorded series of experiments which are all the more remarkable because they were performed in an isolated army post without the aid of special facilities or previous training in research.

Reference

1. Myer, Jesse S.: Life and Letters of Dr. William Beaumont. St. Louis: C. V. Mosby Company, 1912.

"BEAUMONT BECK"

EDITOR'S NOTE: The above photographic study of Otto O. Beck, M.D., Birmingham, Past President of the Michigan State Medical Society and Chairman of the Beaumont Memorial Restoration Fund, was made by Constantine L. Oden, M.D., of Muskegon, Michigan, an old friend. Dr. Oden takes his excellent photographs with a Rolleiflex, using a Strobe light at 3000th of a second. This produces a normal negative from which he may make a normal print; however, to use Dr. Oden's words, "The fun comes in the processing of the prints—by manipulation under the enlarger where it is possible to make any kind of a distortion desired; it works on the same principle as the mirrors—horizontal, vertical, or any kind of distortion can be obtained by printing, holding the paper at different angles, tilting the enlarger and so on."

If MSMS members desire to see additional "studies" of MSMS Officers as fun processed by Dr. Oden, they will be featured in JMSMS from time to time.

To Build a Medical Shrine—Our Privilege

By Otto O. Beck, M.D., Birmingham
Chairman, MSMS Beaumont Memorial Restoration Fund

THE House of Delegates and The Council of the Michigan State Medical Society wisely decided that the restoration of the American Fur Company store on Mackinac Island should be accomplished through the voluntary contributions of Doctors of Medicine of Michigan. This assures a wider interest in the project, for where many have contributed a small sum a personal interest is developed which otherwise cannot be obtained. The ideal would be for every Doctor in Michigan to own one stone or a piece of wood of the building.

At the present writing it is estimated that nearly sufficient funds have been obtained to restore the building. Additional money will be required to furnish the store and to purchase relics of Doctor Beaumont and merchandise of that period.

The plan now is to demolish the old building, except that portion of the original which can be used. The restoration is to begin this spring as soon as weather permits. The building will be divided into two rooms. The larger room will be used as a museum containing writings, paintings, et cetera, of Doctor Beaumont. The smaller room will be set up as a retail store exhibiting the type of merchandise sold in a frontier store in the early nineteenth century.

This project has already created considerable interest in the minds of the public. Last summer many people visited the site, for they had heard from various sources such as radio, television, newspaper and magazine articles of the interesting project planned by the medical doctors of Michigan.

This project is what might be termed a "natural" for it has everything necessary to create universal interest. Geographically it is situated in the center of most of the important activities of the early Northwest Territory. It is on a beautiful State Park which is visited by many thousands of people every year. There Alexis St. Martin on June 6, 1822, was accidentally shot but fortunately recovered from what was considered a

fatal wound. He became a medical curiosity, a man with a hole in his stomach. This in itself has an attraction for everyone. Then on top of it all, Doctor Beaumont used the man with the gastric fistula for his observations on the functions of the stomach. Destiny brought these two together.

X-ray and all other scientific aids developed since 1822 have revealed little more about the action of the stomach than Doctor Beaumont learned without a laboratory. His laboratory apparatus consisted only of a thermometer, test tubes, and a sand bath, using his own time and money, working at remote frontier army posts between bloody Indian wars and cholera epidemics. His story is one of the great sagas of American medical history. His discoveries placed the study of nutrition on a foundation of proven facts.

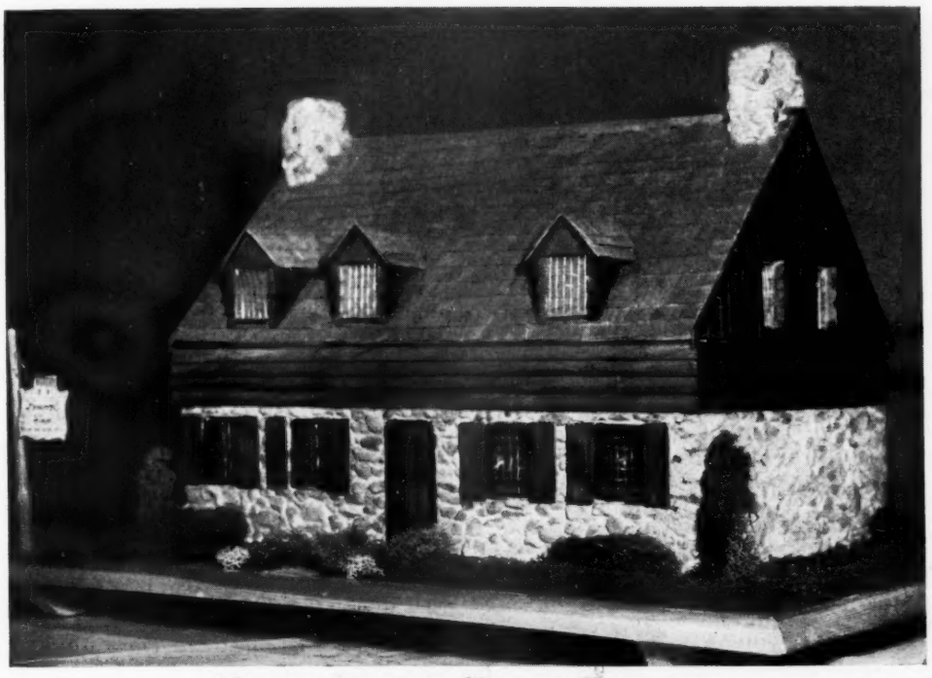
For this experience fate made a curious choice. The Connecticut farm boy, William Beaumont, never attended medical school. He apprenticed himself to a physician, after the manner of the time, eventually receiving a medical certificate. He had no chemistry, little physiology and no knowledge of research techniques. He had tended the wounded in battle and had done some private practice. Though ill trained, Beaumont was a brilliant experimenter, indefatigable in pursuit of fact. He fed Alexis through the mouth and through the hole in his stomach. He studied the digestion of almost every kind of food, cooked, uncooked, whole, chopped, seasoned, and unseasoned. Alexis grew surly and Beaumont observed the effect of emotion on digestion. Alexis often overindulged in alcoholic drinks and the doctor checked the reactions.

Doctor Beaumont became the pioneer physiologist of the United States and the first to make a contribution of enduring value. He ranks with the medical greats of the world.

The highest praise that we can give is to say that Doctor Beaumont's life fulfilled the ideal with which he set out, and which he so well expressed in this sentence: "Truth, like beauty, is when unadorned, adorned the most, and in prosecuting these experiments and inquiries, I believe I have been guided by its light."

The Beaumont Memorial will be a beacon to remind the public that medical progress is rooted in the history of this state. Michigan Doctors of Medicine are privileged to honor this heritage. Let us make the most of this opportunity and in doing so we will honor our medical profession, the people of Michigan, the State of Michigan, and give the Beaumont Memorial the place it deserves among the medical shrines of the world.

When it is completed this shrine to a great medical man will be presented as a gift to the people of Michigan from their Michigan Doctors of Medicine.



MODEL OF BEAUMONT MEMORIAL RESTORATION

Financing the Beaumont Memorial

By W. S. Jones, M.D.
Chairman MSMS Finance Committee and of Beaumont Memorial Working Committee
Menominee, Michigan

EVERY financial report is historical, in a sense. In presenting the financial side of the Beaumont Memorial Restoration, therefore, we must present a few facts of history.

Some ten years ago, the Chairman of the Mackinac Island State Park Commission, W. F. Doyle, was invited to attend the MSMS Annual Session in Detroit. There he met C. E. Dutchess, M.D., then Medical Director of Parke, Davis & Co., Detroit. They discussed a subject of mutual interest—the restoration of the old "Earley House" on Mackinac Island into a Beaumont memorial. It was in the basement of this building that Dr. William Beaumont first cared for his famous and intractable patient Alexis St. Martin. After a visit by Mr. Doyle before the Board of Directors of Parke, Davis & Co., the Board approved a $10,000 grant for the purchase of the Earley property from some nineteen heirs scattered throughout the United States. Therefore, in any historical or financial report of the Beaumont Memorial, W. F. Doyle—who throughout the years has continued to stimulate the erection of the Beaumont Memorial—must be given full consideration and due credit.

Of the original $10,000 Parke-Davis grant, some $5,100 was used to purchase the land and make land surveys. For future expenditures, approximately $900 remains in the hands of the State's Trustees of the Beaumont Memorial: D. Hale Brake, Michigan's State Treasurer; Joseph H. Thompson, of Kalamazoo, former member of the State Park Commission; and Mr. Doyle.

Of the monies granted by Parke, Davis & Co. $4,000 is held by The Council of the Michigan State Medical Society.

From 1,722 Contributors $22,428.90

During the MSMS Presidency of Otto O. Beck, M.D., of Birmingham, the Beaumont Memorial Restoration became his main project. With the approval of the House of Delegates and of The Council of the Michigan State Medical Society, President Beck began a vigorous campaign for funds to build a monument on Mackinac Island to Dr. Beaumont and to the medical profession of this State. By personal contacts and a series of individualized letters, President Beck contacted all members of the Michigan State Medical Society with the following slogan:

"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's Medical men."

Throughout the twelve months of Dr. Beck's term of office, 1,722 Michigan doctors of medicine contributed $22,428.90—mostly in small amounts. The average contribution has been $11.63.

This $22,428.90, added to the $4,000 retained by MSMS from the original grant received from Parke, Davis & Co., totals $26,428.90. (As of 12/31/52.)

Bonds and Cash

The $26,428.90 has been invested, in part, in bonds, with $6,308.10 being held in cash. The purchase price of the bonds was $20,120.80.

The cash on hand will adequately cover any obligations assumed in the early months of 1953, when work on the Beaumont Memorial will start. The bonds (short term United States Treasury Notes) will mature in sufficient time for any necessary use in completing construction of the Memorial on Mackinac Island.

A Total of $40,000 Needed

An additional sum of approximately $13,500 is needed to insure the erection of a permanent Beaumont Memorial. Past President Beck and the members of The Council of the Michigan State Medical Society hope that at least 60 per cent of the members of every component county society will have contributed prior to April 1, 1953. The members in some county societies have contributed 100 per cent—thanks and high congratulations go to these outstanding organizations.

To build the Memorial—and to furnish it in the period of 1822—will mean that some 1,200 additional MSMS members will have to contribute the average sum of $11 or more each.

The Beaumont Memorial is the Michigan doctor's memorial—**your** memorial. Build your share of your own monument. Won't you please send your check today?

See Page 134 for list of contributors.

The Beaumont House

Its Background and Setting

By Emil Lorch, A.I.A.
Ann Arbor, Michigan

THE HISTORY of Mackinac Island, successively under three flags, is reflected in its buildings and their sites.

The site of what is to be known as the Beaumont house was part of a land grant by Lt. Gov. Patt Sinclair to a British officer. The plot of land then went by purchase to a French trader from Green Bay. In 1796 the entire plot was acquired by John Ogilvie, of Montreal, which was then a center of Canadian trade in pelts, the home of the great North West Company and of the Beaver Club for "arrived" traders.

Built before the War of 1812, the Ogilvie house witnessed the capture by the British of Mackinac Island and its return to the sovereignty of the United States. After being the outpost of Ogilvie's supply firm to the fur trade, the house became in 1818 a retail store of the American Fur Company; during its ownership by the Company in 1822 occurred the Alexis St. Martin "accident," which led to the famous experiments of Dr. William Beaumont.

After the decline of the fur trade at Mackinac there followed a long period of residential use of the building while the fish industry flourished, that industry being gradually succeeded by the tourist trade, and the house finally becoming a tourist home. By that time it was of three stories with an enclosed second story porch and had a central heating system and plumbing. Now, about forty years later, the building is to return to its early form.

Fig. 1. The house as rebuilt before 1855 with dormer windows and a look-out platform. The windows have blinds. The neat fence and terrace wall are almost intact. The ground level is lower at the house and terrace corners than in 1946. In 1855 there were no cement walks and Fort Street had apparently not been graded. The original of this picture is in the laboratory of comparative physiology at the Harvard Medical School and appears in "The Life and Letters of Dr. William Beaumont" by Dr. Jesse S. Myer. In the basement of this house Alexis St. Martin was wounded. It was then the retail store of the American Fur Company. This picture shows its appearance after 1855, the upper part of the old structure having been replaced by a new one. It stands at the foot of the hill on which is the fort, measures 25 by 40 feet, and was entered by a door behind the lattice work.

The building fronts on Market Street across from Marquette Park and at the corner of Fort Street which slopes sharply upward toward the Fort. The building is 40x25 feet and stands on a site 49x51 feet in depth, within but 2 feet of the south boundary and a total of 17 feet from the next house, on lower ground, on Market Street. The two-story house at the rear is on higher ground and farther away.

The three principal periods of use of the house can be traced in its construction with the help of the letter-books of the American Fur Company, the deeds of the property and other documents.

Fig. 2. Present view from Fort Street showing terrace without fence; part of stone wall has been removed—also outside stairs to second story enclosed porch. The slope of Fort Street also appears.

Of the first stone-walled cottage there remains the lower portion and part of the large stone fireplace. The existing stairs and partitions and the partial wooden floor are all of a later period; the stairs show little wear.

Over the stone ground story an attractive one and one-half story frame addition was built about one hundred years ago, thus making the two and one-half story house shown in "Life and Letters of Dr. William Beaumont" by Dr. Jesse S. Myer. Its heavy timber or "barn" frame can be traced between the present clapboarding and the plaster on sawed lath. The attic of this bungalow-like building had dormer windows and a roof lookout, a small front porch at second story level, and cornices with sawed, scalloped edges. The second story window spacing differs from that below and the sashes have glass panes larger than those of the first story.

There is white painted interior finish, and the inside doors have the two vertical panels and white china knobs characteristic of the period; there is a brick fireplace and hardwood upper flooring in a second story room where a fire occurred, after which the trim in that room was painted black. Here also is a dumb-waiter from the first story kitchen, one of the early gadgets of domestic architecture.

On the Fort Street side and at the present second story level is a terrace with a fine old lilac and other shrubs. The top of this terrace is above Market Street in front; in back it is at the same level as the lower part of the rear yard. The level of the latter was apparently raised when the height of the building was first increased, thus giving direct access to the rear yard from the house. On the south side, the back yard is higher than the adjoining land and has a stone retaining wall with a buttress for support.

Fig. 3. Part of small rear wing at southwest corner of the building with buttress and retaining wall for rear yard. The slope of the ground of the adjoining lot continues to Market Street where the full height of the first story is above ground level.

After 1909 when the roof, dormers, and lookout were removed and the attic walls raised, the present three-story house emerged. This top portion is of light stud construction; some of the wide roof boards, studded with shingle nails from the two and one-half story house, are used as sheathing. In the third story the interior finish is varnished pine, not mitered. For the central heating system the boiler was set against the stone fireplace and a new flue-lined chimney built in such a way as to wreck part of the old stone fireplace. Although one partition was ingeniously hung by means of an iron rod from the roof frame, alterations led to overloading the construction and the introduction of awkwardly placed posts for support in the first story. Two wooden beams end illogically in front at window openings, one of which was walled up to give support; a wooden post was used for the other beam. These first story elements are obviously not of the original construction. There is no trace of log construc-

tion. The plumbing became possible when the village acquired a water system.

When, in 1818, the American Fur Company rented "Ogilvie's dwelling" and two other buildings including a storehouse, written directions were given to make only necessary repairs; no major structural changes were apparently made until much later.

Fig. 4. Appearance of the building in 1946 and as rebuilt after 1909. Facing Market Street and south of the building is the Doherty residence. The original first story is hidden under the lengthened porch. The house at the rear is an enlargement of a small one-story cottage.

The existing first story ceiling, or second story floor construction, is what is left after several changes were made in the use of the second story space. The present ceiling construction bears no relation to the simple way in which ceiling beams were customarily arranged with the exposed beams spanning from front to rear and resting on walls between openings.

This system used in the French-Canadian "habitant" cottages was familiar to the traders, craftsmen, and other employes who so largely peopled Mackinac from French Canada. They continued to speak French, to carry on their social customs and to like picturesque, warm stone houses with high roofs and projecting eaves, shutters, and casements, hand-wrought hardware, and color.

Visitors to Mackinac during the early part of the last century describe the village as one of low buildings with the exception of the warehouses. The cottages were generally white on the outside, some with bright colored shutters. Red-brown paint seemed to be the favorite but various colors were stocked by the retail store.

The small lot of irregular shape is what was left after selling off the remainder of the British grant which had, as purchased by John Ogilvie and confirmed to him by the U. S. Land Commissioners, a Market Street frontage of 135 feet and an average depth of 150 feet. On the original plot there are now two other houses and the Episcopal Church, all of frame construction. The Doherty house to the south was built about one hundred years ago. A small log house now covered with clapboards forms part of the two-story house at the rear and may ante-date the Ogilvie house. It may be the smaller of two buildings which were on the property when purchased by Ogilvie and shown on Major Gratiot's map of 1817. This map also shows a small wing on the south side of the Ogilvie house. At that time Market Street was the important thoroughfare, Main Street having buildings on only the upper side. Fort Street rises almost the height of the first story in the depth of the house.

Lacking knowledge of Dr. Beaumont and his unique patient, early writers did not mention them

or the house where the "accident" occurred, and the public forgot it all until interest was aroused through the efforts of members of the Medical Society of Michigan.

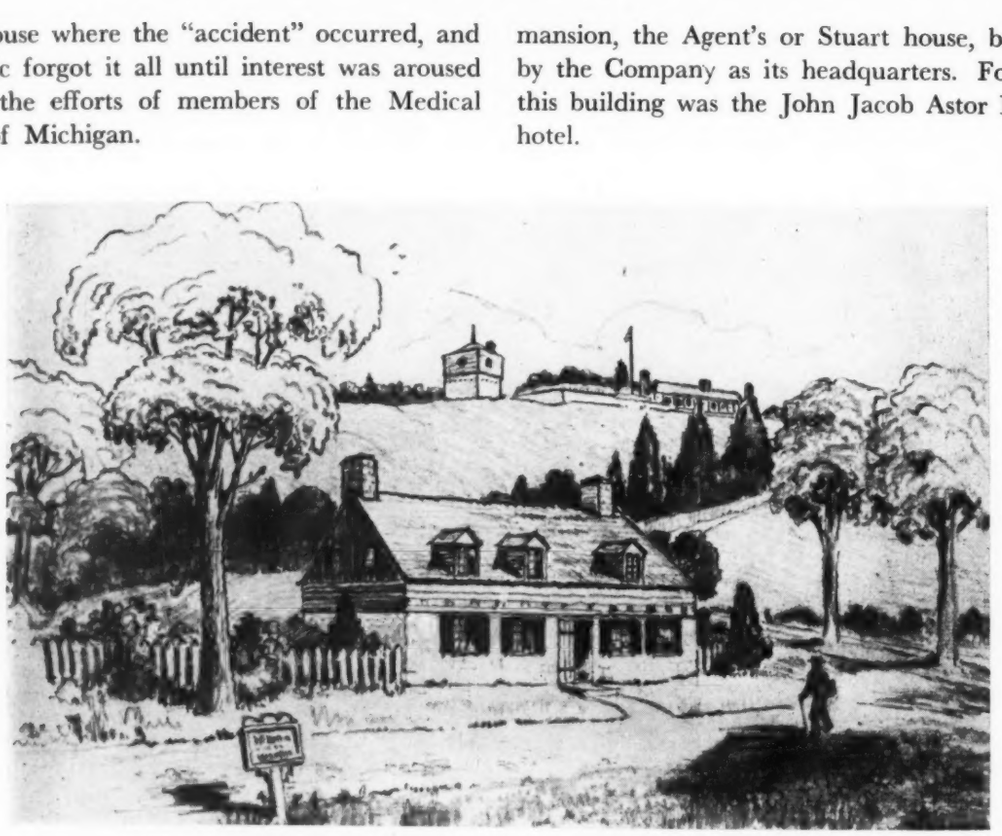


Fig. 5. The Beaumont House as it will appear when completed.

The oldest drawing in which the Ogilvie house appears, and then showing only the roof with dormer windows and look-out, was published in 1855. While we have no description of the lower portion, we do have the stone walls of the first house and some suggestive data. This is more than remained of George Washington's birthplace when a restoration was proposed. No description being found during a long search, a house was built on the foundations according to the well-established local tradition. At Mackinac the Ogilvie house was built by non-residents in the French-Canadian tradition, rather than in the local mode.

From the letter of an employe of the American Fur Company it appears that the "Ogilvie dwelling" had an "upper part," but when in 1818 a large group of the Company's "winterers" were to be sheltered only the ground story of the Ogilvie house was to be used for some of the men. Bark huts were to be built to accommodate the others, involving expense which would have been avoided if possible.

It is significant that the building was the only early private house built of stone at Mackinac; a partial exception is the high basement of the fine mansion, the Agent's or Stuart house, built later by the Company as its headquarters. For a time this building was the John Jacob Astor House or hotel.

The Ogilvie house was apparently of the common one and one-half story height; what remains of the original has much in common with the "habitant" cottages and was probably built by French craftsmen from Quebec Province. This general type is being followed in rebuilding the upper portion.

Enclosed by thick masonry walls, the interior measures 34x26 feet, which space is to be divided into two rooms as at present. The larger room, this having the off-center stone fireplace, is to become the Beaumont Memorial Room and is to contain the well-known painting by Dean Cornwell showing Doctor Beaumont attending Alexis St. Martin. There will also be the portrait of Dr. Beaumont by Deane Keller, and documents and objects of special interest. In the smaller, or south room, there will be exhibited the kind of material known to have been kept in stock by what was a retail store of the fur company in 1822.

After a long period of vacancy of the house, many now look forward to seeing it restored to use on a plane worthy of its important associations, and this it is hoped will be accomplished during the present year. Some also hope that in time the

environment will suggest the original setting including perhaps a stretch of Market Street.

The Market Street of the past was important both as a business and residential street. Along its upper side, near the Beaumont house, stands the impressive group of buildings, largely restored, of the American Fur Company, a monument of the fur trade and of the economic history of Michigan and the nation. Farther south is the well preserved first courthouse, a busy place before the county seat was fixed at St. Ignace. Nearby is the front part of the Edward Biddle house, a unique and precious but weakened fragment of an individual trader's home. When this and the remainder of the Astor Trading Post have been restored, the Beaumont house will be in even better company than now and Market Street will again demonstrate what made the Mackinac region click during its hey-day early in the last century.

NOTE.—In connection with the Beaumont project numerous societies, institutions and individuals have cooperated generously with the writer in a wide search for data; also, considerable documentary and printed matter was consulted. The aim was to explore everything bearing on the fur trade, historically and regionally, that seemed to offer the possibility of help. It is regretted that of the long list of those rendering assistance only the following can be mentioned here:

The Public Archives of Canada
Historic Monuments Commission of the Province of Quebec
The National Archives, Washington, D. C.
The New York Historical Society, N. Y.
Missouri Historical Society
State Historical Society, Wisconsin
Minnesota Historical Society
Mackinac Island State Park Commission
Burton Historical Collection, Detroit
General Library, University of Michigan
The late Professor Ramsay Traquair, McGill University
Dr. Arno B. Luckhardt, University of Chicago

Portrait of Beaumont Artist at Work

By Robert G. Wilder

DEAN CORNWELL

WHENEVER Dean Cornwell hears the rattling of instruments in a doctor's office, his heart goes plunk and his flesh gets clammy. On top of that it brings back vivid memories of the time he spent gathering research material for his famous painting of Beaumont and St. Martin.

It all started when Mr. Cornwell was commissioned by the Wyeth Laboratories of Philadelphia to paint a series of canvasses entitled, "Pioneers of American Medicine." Never before had he been near a doctor save for the times his mother would "drag" him to the family physician in Louisville for a cowpox shot.

Back in 1938 when Wyeth selected the great Beaumont-St. Martin epic for its first canvas, Dean Cornwell spent some time in Chicago with Dr. Arno Benedict Luckhardt, the eminent physiologist of the University of Chicago and collector of Beaumont memorabilia.

"Dr. Luckhardt and I were sitting in his study talking about Beaumont," he related. "Every now and then the good doctor, a Beaumont enthusiast, would give me a demonstration of one of Beaumont's techniques. It was the one where Dr. Luckhardt showed me how Beaumont amputated legs with one quick cut without anesthesia that has made me 'afeared' of doctors ever since."

High above the noise of Manhattan in his studio apartment in New York, Cornwell's eyes flashed as he related his recollections of preparing to paint the Beaumont-St. Martin masterpiece. He is an extremely alert and intense man, slender (because he's on a diet which he doesn't need, he says), and extremely charming.

His studio, where the Beaumont painting was born, is huge and high-ceilinged, cheered by massive panes of glass from floor to ceiling through which the morning sun glows as brightly as the myriad night lights of a city twinkle. In another corner half obscured by piles of sketches, half

completed illustrations, and works which he doesn't like, is a medieval fireplace which works, he says.

In the middle of the room stands the huge easel with palette close by—his tools. On the easel stands a partially completed portrait of the first president of the New England Bell Telephone Company. You see, Cornwell, in addition to being one of the top-ranking illustrators in the United States, is also one of the most distinguished portrait painters.

In another corner of the room, half covered with dust and cobwebs, is an old West Point cadet uniform. This, he says, was worn by the model he employed to pose as Dr. Beaumont.

Dean Cornwell, famous American artist, finishing the "Dr. Beaumont and St. Martin" painting in 1938

In order to paint the Beaumont canvas Cornwell spent almost two years of work. Prior to the actual painting, weeks of research and preliminary sketching were required so that absolute authenticity of detail was insured.

When Wyeth first contemplated the Pioneer series, executives of the company wanted to have an impartial list of truly pioneer figures in American medicine. Organizations from far and wide who heard about the project put forth their beloved candidate. The job of selection was an involved one, a task in which Wyeth wished to have no part. Therefore, Wyeth representatives contacted Dr. Henry Ernest Sigerist who at that time was professor and director of the Institute of the History of Medicine at Johns Hopkins University. He was invited to select those medical pioneers who should be painted.

Heading Dr. Sigerist's list was Dr. William Beaumont whose work gave medicine its first reliable information on digestion. His book, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion," is a classic report on the numerous experiments he performed.

Once the list had been compiled all was in readiness to commence save for the selection of the artist. The work of the top illustrators in the country was examined, and from among this group Dean Cornwell was selected. His skill in the decoration of the Lincoln Memorial, and the warmth and vibrancy with which he captured California's history in the Los Angeles Public Library convinced Wyeth officials that he was their man.

Soon after he was commissioned to do the series, Cornwell journeyed to Chicago to spend some time with the outstanding authority on Beaumont in this country, Dr. Arno Luckhardt.

After spending about a week with Dr. Luckhardt, Cornwell was so "steamed up" with the romance and feeling of the Beaumont-St. Martin incident that he was racing to get started with the canvas.

"It was a challenge to me," Cornwell said. "When I was first approached by Wyeth officials I was only lukewarm, but as I delved into the history of Beaumont and St. Martin I was fascinated.

"Here was Beaumont with no formal medical education who had served for only two years as an apprentice to a New England doctor; then he became an army surgeon. A man of lesser intellect would never have recognized the possibilities Beaumont encountered. But he had New England horse-sense. He knew what he wanted and got it."

As to details Dr. Luckhardt was of tremendous help to Cornwell. His home is filled with Beaumont possessions. Hanging in a glass case is an old military jacket which Beaumont wore. In other places he has Beaumont's account book, his saddle bags, and surgical instruments.

"Reliving those days of 1822 on Mackinac Island when St. Martin was shot in the stomach at the old trading post, fired my imagination,"

Cornwell said.

"Beaumont had his problems keeping St. Martin on hand for his studies. He was a recalcitrant patient in the real sense. I'm told Beaumont eased his trials by keeping plenty of liquor on hand to entertain the French-Canadian," Cornwell added.

"Then, too, when the word spread from settlement to settlement, Beaumont encountered difficulties with other doctors who were more highly trained scientists. They were constantly pressuring him to give St. Martin up to them, but Beaumont would not let him go until his studies were completed."

When he returned to his New York studio, Cornwell set out to find people who would serve as models during the painting of the canvas. To find someone in New York who would serve as a stand-in for St. Martin to the average person might seem like a chore. But not to Dean Cornwell. Through an Indian Trading Post Cornwell discovered a young brave who would do perfectly.

On the second day after he had gone to work, Cornwell received a call from the Indian's wife. He laughed heartily as he told the story. It went something like this:

"Mr. Cornwell, are you going to pay him tonight . . . well, don't, at least not until I get there. Last night he spent all his money in a saloon."

The Indian girl (who in the painting represents St. Martin's wife) came from a New York model agency. She is still posing in New York art circles. The child came from the John Robert Powers Model Agency, and the man who posed as Dr. Beaumont was a young college student from Virginia. "We didn't want to make the child an Indian so I exercised artistic license," Cornwell recalled laughingly.

The scene which is depicted on canvas shows Beaumont in a moment of brown study during his oft-repeated routine collections of gastric juice. It is laid in a Mackinac Island cabin.

"I read Beaumont's book through a half-dozen times. He outlined, as you know, all the details of his work, including the length of the pure rubber hose with which he drained the juices from the opening.

"When it came time for me to start the actual painting I got a doctor up here in my studio who with the aid of Dr. Beaumont's book placed the hose exactly where it should have been over the gastric fistula. I even made him place the bottle where it should be in Beaumont's hand. Then I took photographs of the positions of the furniture and models, and from the photographs I painted the canvas," Cornwell explained.

"Of course, the photographs left a lot to be desired, and I am often asked, how can you paint the finished product with such unerring accuracy? The answer is this: to be a successful illustrator you have to have a background of experience which helps you to form impressions. I knew a lot about buckskin clothes and log and stone cabins from my early boyhood in Kentucky, and that which I didn't know I had to find out. As a matter of fact in order to gather background material for 'Conquerors of Yellow Fever,' another in the Pioneer series, I travelled all the way to Cuba."

Cornwell's most difficult problem in connection with painting Beaumont-St. Martin was to find a picture or likeness of Beaumont. All that was available were artists's drawings, etchings and engravings which reflected only the artist's interpretation of how Beaumont looked. "I came as near to his likeness as I could with the information available."

Painting Beaumont and St. Martin turned out to be a real thrill for Dean Cornwell. He said that he felt as if he had had a complete medical education by the time it was over. He said that he waited a long time for a doctor to question a detail in the painting, and when the question came he was ready for it.

One day a physician at a luncheon complimented Mr. Cornwell on the painting. However, the doctor added that he was surprised to see such an eminent artist commit such an error as to have a rubber hose pictured as early as 1822. The doctor chided him politely that rubber hoses were not even in existence in that era.

In the customary good-humored Cornwell manner, the artist referred the physician to the page in Beaumont's report in which the use of a "pure rubber hose" is mentioned.

"I felt better after that," Cornwell added.

"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

The Future of the Beaumont Memorial

By W. F. Doyle
Chairman, Mackinac Island State Park Commission

TO OUTLINE the "Future of the Beaumont Memorial" without recording for history some of the heretofore unreported activities of my associates on the park commission and their eagerness to assist in preserving and restoring the embryo of this shrine to medical history, would be to omit an important chapter from an otherwise momentous chronology.

The seed of restoration was actually planted by two citizens of Ann Arbor, Dr. Fred A. Coller, noted for his work in the same field of medicine that made the name "Beaumont" internationally famous, and Joseph H. Thompson, chairman of the Mackinac Commission in 1941. My job was to nurse that seed to maturity.

I was a patient in University Hospital at the time. Dr. Coller consulted on *my* "stomach ailment." Joe Thompson visited me each day to help pass the monotonous hours between x-rays, basal metabolisms, blood tests and the many other strange experiences of one undergoing a "complete physical." Because there was no "window" in my stomach through which the doctors could peer, it was necessary for them to take the longer, but more scientific, course to determine the cause of intestinal "kick-ups."

It was on that occasion that the three of us drew the hoped-for blueprint and recorded in our mental notebooks those aspirations which are now approaching reality. The architecture, the financing, the other historical aspects and the progress of that early dream are all contained in articles appearing elsewhere in this edition of THE JOURNAL.

The future of this shrine, once the physical work of restoration is completed, rests in the hands of two great institutions, the Michigan State Medical Society and the State of Michigan itself. When finished, the building will be the property of the State, but both the active interest and the close and jealously guarded determination that it not become "just another building" must be constantly insisted upon by those who follow in the footsteps of the medical doctors and Park commissioners of today.

The "Earley House," as the old building is commonly known to Mackinac Islanders, in the years ahead, should be properly fitted and equipped with such papers, instruments, etchings, drawings and other historic relics as will give a visual picture of the scene enacted by Beaumont, St. Martin and others on the day of the near fatal shot-gun explosion—June 19, 1822. The State should assume the maintenance and responsibility. The doctors should willingly accept the challenge to keep a vigilant eye on its use, interior care and constant search for ways to make it the recognized Beaumont shrine of the world. Other communities have rightful claim to the memory of Beaumont, but only on Mackinac Island where the actual accident took place and where the original medical experiments were performed is there first claim to edify the name of this famous person.

And to the Mackinac Island State Park Commission of the future let there be a word of admonition. Let it never be forgotten that on the very soil over which they hold jurisdictional authority a great chapter in Michigan, American and medical history was written. That chapter must be preserved.

In the years to come when countless thousands of persons visit the Island to enjoy its beauty and to drink of the fragrant vintage of the early nineteenth century, let the Beaumont shrine tell its own story of the life and hardships of the voyageur, the early settler, the men and women who braved the wilds and hazards of the "north country" that the spread of commerce, religion and medicine might not be impeded. Let it portray the brilliant and successful efforts of the young Fort surgeon to save a life when the lives of fur trappers were not held in too high a regard.

After the restoration is finished, a permanent standing committee with provision for rotation and supplement should be named. This committee should be composed of interested doctors who will dedicate themselves to the "Future of the Beaumont Restoration." A similar committee of Park Commissioners should be created.

Together, those interested citizens can make Mackinac Island a gathering place for annual pilgrimages of doctors and lay people the world over.

The seed has been planted: the ground is fertile. The future rests with those who love medical history and will cherish its preservation.

Whatever little contribution I have made is insignificant in ratio to its fullest potential.

Preventive Medicine in the General Practitioner's Office

By J. S. DeTar, M.D.
Milan, Michigan

IN A PANEL discussion like this one it is one thing to tackle a subject such as has been assigned to me, and it is another thing to stick to it. Preventive medicine most assuredly is practiced in the general practitioner's office but is by no means limited to the office, because the general practitioner spills over into the preventive field in his county medical society meetings, in his contacts with his local health department, in his membership in his local community health council, and in his postgraduate training sponsored by the American Academy of General Practice. So, while I may slide over into the fields to be covered by Dr. Gassett, Dr. Baehr, Dr. Dana, and Dr. Bierring, I doubt if I can slide very far in my allotted time. So let's start in the general practitioner's office and see where we go from there.

Role of the General Practitioner

A general practitioner is supposed by some to be a mouse-like individual with a chronic inferiority complex about his medical status, who sits in the back row at medical meetings taking notes with a dull pencil on the edge of the morning paper. With all the timidity and reticence supposed to be characteristic of my medical classification, I should like to admit to you that I believe the general practitioner to be by all criteria the most important cog in the preventive medicine machine. With his co-operation, organized public health projects may succeed. Without his co-operation they are doomed before they start.

This is because it is the general practitioners who outnumber all the specialists combined, who generally see the patient first, and who are the family counsellors in medical matters. I hold that this broad statement applies to educational campaigns conducted by the United States Public Health Service, by the State Health Department, and by the local health unit. And if this be true, it might be worth while to spend a little time investigating the general physician's place in the preventive medicine picture.

Actually I have only one point to make. It is this:

The general practitioner is the key man in the preventive health field. He is generally a very busy man, and cannot be expected to perform well in specialty fields unless he has had special training in those fields, and is able to take time from general medicine to devote to special medical interests. Public health is a special field requiring special training, just like thoracic surgery. In the preventive field the general practitioner relies on organized public health experts to map out the programs first, then to seek his co-operation to implement those programs. However, in preventive medicine, as in other fields requiring special knowledge, the G.P. must be educated and led, not pushed; he is still quite an individualist. The final success of any project in the preventive health field depends on the close co-operation and the integration of the efforts of the leaders in organized public health, and of the general practitioners.

Immunizations in the Office

If you will forgive personal references, I should like to draw on local experiences; case studies, if you will. I live and practice in a little town of 2,500 persons in a county of 100,000. Four years ago our county health department director informed the county medical society that immunizations in the county were not at the desired level. I didn't believe him, so I took a sample of 100 babies delivered in my practice.

I was amazed to discover that only 47 per cent of my own babies, delivered by myself, had been immunized at the end of the first year of life, despite routine instructions to the mothers to bring in the children at six months of age. Other surveys yielded like reports. In order to improve our Public Health standards, the county medical society agreed to co-operate in immunization clinics (free clinics) over the county. The plan worked beautifully. Recently, after four successful years of free immunization clinics, the county health department director informed the county medical society that immunization was at a high level, and perhaps the free immunization clinic idea could be dropped. The county medical

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society refused to discontinue the free clinics. This is an interesting commentary on the change in attitudes of general practitioners over the last decade, from one of at least disinterested toleration of public health efforts, to one of enthusiastic co-operation.

Parenthetically, I made another survey last week of 100 obstetrical deliveries made in 1951 to see if my percentage of immunizations had increased in the past four years. (You see, it does something to a general practitioner who is giving free immunizations at the school to a line of children, to recognize the banker's daughter and the manufacturer's son in the line.) So I decided to see if my present methods in preventive medicine had improved my score. I was surprised to find that of 100 cases:

78 had completed their immunizations
3 had completed all except for small pox
3 had taken two immunizations only
3 had taken one immunization only
12 had not kept their appointments
1 had refused

Thus, 87 per cent had responded to the system used, which consists of making an appointment for the first immunization two months after the six-weeks postpartum office call. Then, on each call, a definite appointment is made for the next immunization in one month, until all are completed. Then a postcard is filled out to be mailed one year hence when a booster dose is due. The system really works, and I believe my patients are average people living in an average town.

My conclusion is just this: After a general practitioner has made every effort to achieve 100 per cent immunization in his practice, he should then welcome the help of the county health department to pick up the stragglers. Then he should co-operate in free clinics for the purpose.

Other Fields

Immunizations constitute only a small segment of the preventive medicine field of the general practitioner. Heart disease, cancer, tuberculosis, arthritis, as well as psychosomatic disorders, all have their preventive phase (or early detection phase) and their treatment phase. I wonder how many people here know the extent of the program the general practitioners have set up for themselves in the preventive field—through their own organization, the American Academy of General Practice. A mere five years old, this group of over 15,000 general practitioners has undertaken to raise its own standards by a requisite of continued postgraduate study to maintain eligibility for membership, by intense activity in the medical educational field, and by constant efforts in the hospital field to preserve for the physician in general practice the right to practice medicine and surgery as permitted by his special qualifications and his license.

The American Academy of General Practice

From the standpoint of preventive medicine, you would be interested in some of the subjects accorded prominent places on the scientific agenda at the annual meetings of this general practitioner organization during the past two sessions.

Dr. Paul Popenoe talked about marriage and family relations; Dr. William C. Menninger talked about the sexual aspects of marriage; Dr. Dorothy Baruch talked about new methods in child discipline; then they engaged in panel discussion on, "Counseling Factors in Family Life." This entire group of discussions was devoted to prevention of disease in the field of psychiatry—a preventive treatment which must be administered by general practitioners or not at all.

Dr. C. F. Gastineau talked on, "Obesity and Thinness." Dr. Richard A. Kern discussed, "Our Geriatric Patients" last year, and "The Forties" this year, and Dr. O. Spurgeon English talked on, "Problems of the Teen-Agers." Dr. George M. Wheatley's subject was, "Help Immunize Me Against Accidents."

I mention these titles because they represent a distinct victory for the forces of preventive medicine; here we see the general practitioners, through their own organization, focusing attention directly on the prevention of disease—a field occupied fifty years ago by only the most progressive of public health leaders.

The Health Council Idea

We have talked about preventive medicine in the doctor's office, in immunization clinics, and in the physician's postgraduate studies. Where does the Health Council come into the picture on the state and community level?

Actually, the whole health council idea is a projection of the concept of preventive medicine from the state level down to the community level —where general practitioners and public health directors, and all others interested in health may find common meeting ground for the solution of their community health problems. In Michigan, both delegates from the State Medical Society to the State Health Council are general practitioners.

And, interestingly enough, as an example of the natural trend toward co-operative effort between organized medicine and public health, we now find working with these general practitioners on the Board of Trustees of the Michigan Health Council and with representatives of farmers, nurses, hospitals, Blue Cross-Blue Shield, three outstanding public health directors, one from the State Department, one from Detroit, and one from Ann Arbor.

State Health Council and Preventive Medicine

You may feel that a discussion of State Health Councils is far afield from my title of "Preventive Medicine in the General Practitioner's Office." Not so far, if you follow this sequence of events: last year the Michigan Heart Association pondered over the idea that perhaps it is illogical to ask people to go to see their doctors once a year for a cancer examination, once a year for a heart examination, once a year for a diabetes examination, once a year for a rheumatism examination, and so on. So the Heart Association proposed to the Michigan Health Council, which has all these interests represented on the state level, that they all should be called together to see what could be done.

Action was fast. Representatives of the State Medical Society, of the Schools of Medicine, of State Associations of Heart, Diabetes, Arthritis, Cancer, and Tuberculosis met, discussed, and agreed that an examination to be called a "Periodic Health Appraisal" should supplant the various special field examinations. A hundred questions were boiled down to fifteen—to be answered by the patient. Work is in progress now to educate the public as to the need of a periodic health appraisal, and to educate the medical profession as to the need of doing an adequate examination when the patient presents himself at the doctor's office, with completed questionnaire in hand. The potentialities of this movement are tremendous.

This type of effort represents a new high in co-operation in the field of preventive medicine. And it all channels right down to the general practitioner's office, where cancer, and heart disease and psychoses may be detected while they are still curable.

Teamwork

Preventive medicine, as an entity, can certainly not be limited either to the health director's office, or to the physician's office. Close, continuous co-operation between the two is essential if the job is to be done.

Tuberculosis

Close co-operation is necessary in tuberculosis case finding and follow-up care. Cases are usually discovered either by the general practitioner or in a mass chest x-ray campaign. If the State Health Department discovers it first, the physician is notified, calls in the patient, procures x-ray follow-up and sputum tests, and usually arranges with his county health department director for sanitarium care if necessary.

Sanitation

Consider this example of co-operative effort in the sanitation field. At 5:30 a.m. a Traverse City physician phoned the health director explaining that within the past three hours he had seen three patients with severe gastroenteritis. The director went immediately to his office and asked medical society aid. By mid-morning, a pin map was set up showing that all cases were falling in one-half of the city. Prompt investigation revealed defective chlorination in one pump serving this half of the city. This problem, solved within twelve hours, is a beautiful example of the co-operation necessary to achieve results in the preventive field.

Contagious Disease

In the field of contagious disease fast action by both general practitioner and health director is often necessary. A Barry County physician called his health director at 1:30 a.m. requesting diphtheria anti-toxin. The director was at the patient's home in thirty minutes with the anti-toxin. The parents allowed treatment of the patient, but refused to allow immunization of others in the family for religious reasons. The patient was saved, but one younger brother died. In this epidemic 400 school children had positive throat cultures. Twenty-two cases of diphtheria developed—and there were four deaths. Here was an instance in which the general practitioner and the health director worked hand in hand for weeks. Neither could have done the job alone. This is also proof of the need for more complete immunization.

Contamination

An interesting Sherlock Holmes story of a physician and his health director demonstrate the interdependence of the two. Each would be at a great disadvantage without the other.

One Sunday morning a general practitioner was called to several homes where he found evidence of food poisoning. He called the health director; together they visited several homes. They traced all cases to a single restaurant. Soon they found that gelatin dessert had been ingested by all patients. Working together that afternoon they found that the chef used tartaric acid crystals in his recipe. They checked his tartaric acid crystals and found that the druggist had provided tartar emetic in error. That same afternoon they appeared on the radio together and explained that the situation had been corrected through co-operation of physician, health director, restaurant owner and druggist. (All medical bills were paid by the druggist's insurance company.)

Part-Time Health Officers

"Can a general practitioner, with his increased knowledge and awareness in the field of preventive medicine, do also the job of the health director, together with his practice?"

Considering that one-third of all counties in the U.S. still are unprotected by organized Public Health Units, the question is still important although it was more commonly asked a generation ago. Seeking an answer, I secured permission from my county health director to borrow his appointment book. Selecting at random one week this winter—(I just happened to open to January 14), I checked his schedule for the purpose of determining, if possible, whether I could handle public health work in addition to private general practice.

Here is what I found for Monday, January 14:

8:30: Review of correspondence.
9 to 10: Meetings with individual staff members.
10:05 Meeting with chief public health engineer, supervising public health nurse, 2 assistant nurses, and office manager to plan week's activities; discussion of proposed sanitary sewer; discussion of sanitary fill; discussion of impending county medical society booster immunization program.
12:00: Luncheon with all staff members.
2:30: Addressed Federation of Women's Clubs on "Activities of the County Health Department."
7:30 to 9:30: Attended city council meeting to advise councilmen on rodent control, milk and meat inspection, restaurant inspection.

Every day was just like that. Totaling up his activities for the week, I found the following in his week's activities:

Office staff conferences—4
Office conferences with individual callers—9
Luncheons with office staff—1
Speeches—1
Evening meetings—3
Afternoon meetings—1
Branch office calls—1
Scout exams—1
Meeting to advise on county building code—1
Hours in teaching public health—3
Official dinners—1
Trips to legislature—1
Conferences with legislators—2
Conference and trip on migrant labor problem—4 hours
Meeting with subdivision planners, with trip—1
Meeting with group seeking annexation to city—1

I asked this director what he did with his spare time. He replied that he spent most of it on the phone, "concerned with everything from state and local legislation to citizens' questions as to why a chicken stinks when it is purchased at a local market." I will confess that I was amazed to learn the extent of the work of a county health department director. As a general practitioner in an average town, with an average practice, I am frank to confess that I could not do the work of a public health officer on county or township or community level for two reasons: I don't have the time, and I don't have the training. It will be a happy day for the health of the American people when every county in the United States is protected by an organized public health department.

Conclusion

Preventive medicine is a broad field, and it is becoming more important with every passing decade.

The prevention and early detection of disease are the general practitioner's job. Without his co-operation success in this field is impossible. The GP looks to public health directors for leadership on the local level—for guidance in matters of preventive medicine. Both practicing physician and public health director would do well to capitalize on the most potent community force in the preventive medicine field: the community health council. No one has a corner on this market. All it takes is a man with a purpose and some drive behind the purpose. And, just a word of advice to public health directors: when you have a good project, and you know it is good—and you want the support of the general practitioners, don't assume we are unwilling just because we are slow to jump on the bandwagon. Just lead us gently; don't shove us. It works better.

Exfoliative Cytology in Periodical Physical Examinations

Progress Report

By Nelson Taylor, M.D., and
Donald G. Ross, M.D.

Grosse Pointe, Michigan

IN 1950 an initial report[16] on the value of exfoliative cytology in periodical physical examinations was published in this journal. Since that time the study has been continued. In four years of observation it now includes 1,554 smears on 1,289 patients, with malignancies established in nineteen patients.

Technique

The method by which material may be obtained for examination according to the procedure of Papanicolaou has been previously reported.[16] The only change from that procedure is the variation in obtaining prostatic specimens. A broader field of observation is covered if, after prostatic massage, the urine is collected. This specimen is immediately centrifuged and the sediment fixed. The slide can then be examined for malignant cells. This provides a survey of the complete genitourinary tract rather than of the prostate alone. If malignant cells are observed, measures may be taken to localize the site of origin.

New methods for obtaining gastric specimens,[18] expanded use in detecting pulmonary neoplasms,[11] as well as modifications of the vaginal smear[14,17] have been recommended. Thus, there are constant efforts to improve the efficiency and accuracy of this phase of cancer detection.

Material

In this series, all were private patients and most were seen during the course of complete physical examinations. The study was begun in June, 1948, and terminated in March, 1952.

Results

The series (Table I) included 1,554 smears on 1,289 patients. The total number of malignancies was nineteen. In this group there were 1,281 negatives, 265 questionable reports, and one false negative.

TABLE I. EXFOLIATIVE CYTOLOGY SMEARS

	Negative	Questionable	Positive	Total	
				Patients	Smears
1. Lip	1			1	1
2. Mouth		1	1	1	2
3. Feces	1			1	1
4. Peritoneal	2		2	2	2
5. Breast		1	1**	1	2
6. Nipple Secretion	4			4	4
7. Pleural	11	2	6	11	13
8. Gastric	18			18	18
9. Sputum	19	3	3	19	22
10. Urine	20		(1*)	21	21
11. Prostate	253	18	1	254	272
12. Vaginal	951	240	5	956	1196
	1281	265	19	1289	1554

**Papanicolaou negative; biopsy positive.
*Same patient as prostatic positive.

Papanicolaou smears were examined in one patient with an ulcerating epidermoid carcinoma of the sublingual region. The first attempt was reported as questionable and the repeat was positive for malignant cells. A smear was made on one lip lesion and this was reported as negative. One attempt to make a Papanicolaou smear from fecal material was reported as negative. Smears were made from ascitic fluid of two patients and malignant cells were found in both, one had a cystadenocarcinoma of the ovary and the other a lymphosarcoma.

One patient had a massive, ulcerating medullary carcinoma of the breast. A direct smear from this was reported as negative although biopsy was positive. Nipple secretions from four patients were negative. Aspiration of pleural fluid in eleven patients revealed malignant cells in six.

Papanicolaou smears on fasting gastric specimens in eighteen patients revealed no malignant cells. In two of these patients, radiographic studies were reported as gastric ulcers, probably malignant. Pathological sections of gastrectomy specimens in these two revealed benign ulcers. Sputum Papanicolaou smears in nineteen patients included the finding of malignant cells in three who proved to have bronchogenic carcinomas. Cytologic smears on the sediment of centrifuged urines in twenty-one patients included one in whose specimen malignant cells were demonstrated. At operation, adenocarcinoma of the prostate was found. This, also was the only positive in 253 men on whom prostatic smears were made.

Vaginal smears (Table II) comprised the majority of the examinations: 1,196 smears on 956 patients. Smears were reported as questionable or positive and repeated in 240 patients or 25 per

TABLE II. VAGINAL SMEARS

Patients	951	100%
Repeated Tests	240	25%
Confirmed Malignancy	5	0.52%

Ratio: 1 Positive : 191 Patients.

TABLE III. OPERATIONS

Dilatation and Curretage	13
Cervical (Stump) Amputation	2
Hysterectomies	11

TABLE IV. UTERINE MALIGNANCIES

1 Carcinoma in Situ
2 Early Invasive
2 Late Invasive
(3 advanced carcinomas in patients who earlier declined complete examinations).

TABLE V. VAGINAL SMEARS

Age Range		
Decades	Patients	Malignancies
III	27	
IV	159	
V	276	1
VI	176	1
VII	78	2
VIII	27	1
IX	9	

TABLE VI.
DETECTION COST IN UTERINE MALIGNANCIES

	Patients	Cost to Patients
Total	951	$6657
Negatives	946	6622
Malignancies	5	35
To Find One Malignancy	5	1337 (or $7)
To "Save" One Malignancy	3	2228 (or $7)

Explanatory Note To All Patients

The exfoliative cytology (Papanicolaou) examination is a SCREENING test for cancer of ONE PARTICULAR PART. While the accuracy of interpretation is constantly increasing, it is still not 100 per cent. Occasionally there are technical reasons for repeating the test.

cent; five were positive for malignancy. This is a ratio of 1 positive in 191 patients.

Operations (Table III) on this group of women included curettage and cervical biopsy in thirteen instances, among which were five with uterine malignancies. These were done chiefly on the indications of gross cervical lesions such as polypi or erosions. Amputations of cervical stumps were accomplished in two patients with persistently questionable Papanicolaou smears because of the greater incidence of cancer in these retained fragments following supracervical hysterectomy. Malignancy was not found in either case. Early in this study, one hysterectomy was done elsewhere solely on the indication of a questionable Papanicolaou. Serial pathological sections were not run, but on the routine sections, no malignancy was demonstrated. Additional hysterectomies were done in seven women for other indications and also in the two patients with early invasive carcinoma and the one with carcinoma *in situ*. The two patients having advanced carcinomas received only radiation therapy (Table IV).

The age range is shown in Table V with the occurrence of malignancies in the fifth to eighth decades.

The fee cost of detecting uterine malignancies is shown in Table VI and totals $6,657 for the 951 patients. The 946 patients who received negative reports paid $6,622. Thus the five patients receiving positive reports paid only seven dollars each, or a total of $35. The fee cost of detecting one uterine malignancy was $1,337. With the presumption that the two patients with early invasive carcinoma and the one with carcinoma *in situ* have been treated in time to eradicate the cancers, then the cost of detecting each "cured" patient was $2,228.

An incidental observation in this study has been identification of the phase of the menstrual cycle (Table VII) in many of the smears. Based merely on calendar estimations of accuracy, it is presumed that agreement occurred in seventeen of twenty-one reported as being preovulatory, in seventy-one of ninety-three postovulatory specimens and in 356 of 366 with low estrogen levels. In sixteen patients receiving estrogen therapy, evidences of exogenous stimulation were noted in all of their smears. Hyperestrinism was noted in four instances, but without estrogen assay, there was no confirmation.

During complete examinations, breast transilluminations were recorded in 314 patients (Table VIII). By comparing the relative degrees of opacity with estrogen levels as reported on Papanicolaou smears, direct correlations were noted. That is, the more opaque the mammary tissue to transillumination, the higher the estrogen level, or, the translucency was found to vary indirectly with the estrogen level. Agreement was found to occur in 276 of 314 instances, or 88 per cent. Eight of the patients where there appeared to be discrepancies were found to have hypothyroidism. Mammary myxedema, therefore, accounted for the relative opacity in this additional three per cent, raising the degree of accuracy to over 90 per cent.

TABLE VII. CYCLIC DETERMINATIONS

	Reports	Agreement
Preovulatory	21	17
Postovulatory	93	71
Low Estrogen	366	356
Exogenous Stimulation	16	16
Hyperestrinism	4	

TABLE VIII. BREAST TRANSILLUMINATION

Total	314	
Agreement	276	88%
Myxedema	8	3%

Translucency varies indirectly with the estrogen level.

During the four years of this study (Table IX), forty patients were examined each year; 103 patients were observed for each of three years and 150 for two years. No patient was found with uterine malignancy who previously had had a negative smear. On the other hand (Table IV) three patients who failed, as previously advised, to have physical examinations which would have included Papanicolaou cervical smears, later were seen with advanced uterine malignancies.

Discussion

The use of exfoliative cytology as a diagnostic (as contrasted with screening) method is exemplified in the first ten sites listed in Table I. The incidence of malignancy in this group is disproportionately high because, in most instances, cancer was suspected clinically. In all but one case (breast), the reported smear was verified. Thus, it would appear to be of value as a diagnostic measure.

However, none of the thirteen patients in whom suspected malignancy was verified, survived. Therefore, utilized in this fashion, the test becomes of value statistically but of little help to the patient. This limited study emphasizes the *real* usefulness of the test. That is, its application in the office of the private physician: general practitioner, surgeon, gynecologist or internist who is willing to devote the brief time and effort required to screen patients for malignancy. Every such office where comprehensive physical examinations are done thus becomes a cancer detection center.

One uterine cancer in every 191 patients is not a high percentage yield, but to the one person "saved" by the early establishment of that diagnosis, this method becomes of inestimable value. Other investigators have found the incidence of detection to be between 0.2 and 2.5 per cent.[5,6,7,9]

TABLE IX.

Patients Observed for Two Years	150
Patients Observed for Three Years	103
Patients Observed for Four Years	40

The cost of finding one patient with uterine malignancy in this series may be expressed in more than one way. It may be based on the fee charged for the service: seven dollars for interpretation of the smear. Thus, to the patient with the cancer, the total expense of finding her lesion was seven dollars. It may also be stated that the cost, spread over 191 patients, was $1,337, or, based on the number of patients probably "cured," $2,228 to "save" one patient.

This differs greatly from public health or charity clinic surveys where the cost has ranged from[9] $120 per case detected to[3] $357.45. These latter figures are based on the expense of materials and technical help with no charge for professional interpretation.

Even these figures[8] are excessive from the standpoint of public health and only one life in 191 is not statistically important in bureaucratic parlance.

Hence, an excellent opportunity is afforded private practitioners to save lives by adding this simple procedure to the all-important periodical physical examination which will detect not only cancer, but also heart disease, tuberculosis, diabetes, arthritis, multiple sclerosis and all the other scarehead diseases which recurrently have "weeks" devoted to their publicity.

It must be emphasized as has been done before[16] and elsewhere[4,10] that exfoliative cytology does not replace established diagnostic measures. Its chief value is in screening and not, as is sometimes advocated, using it in "selected cases."[15] Others[2] have stated that the percentage of false negative Papanicolaou smears is too great, as much as 3 per cent. Thus in our small series of 951 patients, twenty-nine would be expected to have uterine malignancy —quite unlikely.

However, this does serve to underscore the need for annual physical examinations which include Papanicolaou smears, although it may be found later that the intervals between tests may be safely prolonged. In any event, many years will be required to finally evaluate the method.

It now appears that the need for extension of the routine use of exfoliative cytology is pressing. It is hoped that the procedure which includes prostatic massage preceding collection of a urine

specimen for Papanicolaou stain of the sediment may enhance the value of the test in men.[12,13] More frequent use of sputum Papanicolaou smears[1,11] may serve to make the outlook in pulmonary malignancy a little brighter, also.

Summary

1. A four-year study of exfoliative cytology includes 1,554 smears on 1,289 patients with nineteen malignancies.

2. Smears have been found positive for malignancy on a lesion of the mouth, from ascitic fluid, pleural fluid, sputum, urine, prostatic fluid and on vaginal smears.

3. An improved method of genitourinary screening provides for staining of sediment from urine excreted after prostatic massage.

4. On 956 patients 1,196 vaginal smears were obtained and five were positive; one malignancy in 191 patients.

5. The fee cost of detecting one uterine cancer might be considered to be $1,337 but actually it is only $7 because the patient with the malignancy pays for only one smear. (The procedure is reportedly too expensive in proportion to the number of individuals "saved" to justify its use in public health.)

6. Estimation of the phase of the menstrual cycle is only moderately accurate but identification of reduced estrogen level is quite reliable.

7. Translucency of the breast appears to vary indirectly with the estrogen level.

8. During this study no malignancy occurred in tissue from which a previously negative smear had been obtained.

9. Three patients who had previously refused exfoliative cytology later were found to have advanced uterine malignancies.

10. The period of observation in this study has been too short and the size of the series much too small for statistical significance.

Conclusions

I Exfoliative cytology is an important screening procedure in detection of malignancy, especially uterine.

II Its greatest value is in association with periodical physical examinations.

III This method should supplement but not supplant established diagnostic measures.

Acknowledgment

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Most of the smears reported in this series were interpreted by Doctors Joseph Kasper and George Fritz.

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Dysphagia

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IN A DAY when the number of articles approaches the reader potential we are content to present a subject which attracted considerable attention at the recent AMA convention in Atlantic City. The content is not original and the intent is to bring to general awareness the diagnostic aids and treatment available to the patient who complains chiefly of difficulty in swallowing.

Dysphagia is the most common symptom of esophageal disease. Occasionally there will also be a complaint of painful swallowing, burning on swallowing, and full sensation in the chest, but difficulty in swallowing will be the voluntary complaint. Of considerable importance in such cases is a detailed history as to:

(1) the nature of the onset of the dysphagia, whether sudden or gradual,

(2) the periods during which the symptom is most evident, i.e., between meals, at beginning of the meal, toward the end of the meal, et cetera,

(3) the nature of foods causing the most severe aggravation of symptoms, i.e., solids, liquids, spicy foods, et cetera,

(4) other debilitating diseases which coexist or precede the symptoms, and

(5) whether vomiting occurs or whether food is regurgitated without evidence of having been in the stomach.

The following outline and classification will help the physician in making a differential diagnosis:

I. *Obstructive Lesions*
- A. Foreign body
- B. Tumor
- C. Caustics—Cicatricial Stenosis
- D. Cardiospasm (Achalasia)
- E. Diverticulum
- F. Congenital Stenosis
- G. Congenital Atresia with Tracheo-esophageal Fistula
- H. Esophageal Varices
- I. Scleroderma
- J. Plummer-Vinson Syndrome
- K. Angio-neurotic Edema

II. *Functional Dysphagia*
- A. Globus Hystericus

III. *Extrinsic Causes*
- A. Hiatal Hernia (Short Esophagus included)
- B. Aberrant Vessels (Dysphagia Lusoria)
- C. Outside Pressure: Abscesses of neck, aneurysm, aortic or cardiac enlargement, cervical exotoses, glossitis, Hodgkins' disease, Ludwigs' disease, leukemia, lymphosarcoma, laryngeal lesions, parotitis, tonsil hypertrophy, et cetera.

IV. *Inflammatory Lesions*
- A. Esophagitis—acute, chronic
- B. Tuberculosis
- C. Syphilis

V. *Neurological Lesions*
- A. Myasthenia Gravis
- B. Jugular Foramen Syndrome
- C. Multiple Sclerosis
- D. Progressive Bulbar Palsy (and Pseudobulbar Palsy)
- E. Acute Poliomyelitis
- F. Thrombosis of the Posterior Inferior Cerebellar Artery
- G. Other diffuse central inflammations or CVA's, e.g., botulism, rabies, tetanus, encephalitis, diphtheria

I. Obstructive Lesions

Foreign Body.—A foreign body in the esophagus promptly provokes dysphagia. Moreover, there is usually painful swallowing and a reluctance on the part of the victim to chew and dispose of his own saliva which will accumulate in the hypopharynx.[8]

The types of foreign bodies vary with the age of the patient. The child is most likely to have a coin, safety pin, or some small toy that instinct has prompted him to place in his mouth. In the upper extreme of years, edentia, whether compensated or not, hasty eating, and carelessness in masticating meat with bone subjects this group to ingestion and obstruction by chicken bones, pork chop bones and large boluses of meat of any type.

Diagnosis is not difficult with the symptoms

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above present. A child who cannot relate his sensations may hold his head stiffly to one side or may show a preference to a prone position. The x-ray is essential and should include all the structures from the nasopharynx to the ischial tuberosities. Flat objects, such as coins, always lie with their greatest diameter in the coronal plane of the body when in the esophagus, in the sagittal plane when in the trachea or larynx. A lateral film low down on the neck but clear of the shoulder will often show a bone or other semi-opaque object invisible in the anteroposterior exposure. A teaspoon of barium swallowed while being observed on the fluoroscope may localize the impediment. A wisp of cotton given just prior to the ingestion of the barium has been found to localize an impacted bone that is otherwise not visualized on the x-ray plates. The most frequent site of obstruction is in the cervical esophagus just below the cricopharyngeal constriction.

Treatment is removal by peroral esophagoscopy.

The prognosis of unremoved foreign bodies can be considered to be ultimately fatal. In experienced hands, removal is attended by less than 2 per cent mortality.

Tumor.—Great strides are today being made in the diagnosis and treatment of this distressing disease. Benign tumors, which are usually myomas, do occur[21] but are very rare.

Carcinoma of the esophagus is essentially a disease of men (10:1) over forty. Usually it is at about the level of the tracheal bifurcation.[29] While the lesions may be polypoid, infiltrative or ulcerating, all eventually show ulceration. Dysphagia with solids is the usual signal symptom.

Diagnosis is by barium visualization of the esophagus and esophagoscopy.

The advent of antibiotics and the discovery of the adaptability of the well-mobilized stomach to the thoracic cage have removed some of the fear once attendant on this diagnosis. However, the outstanding factor in the high mortality rate is the failure of the physician to consider carcinoma first in the differential diagnosis of dysphagia.

Statistically this lesion accounts for 2 per cent of cancer deaths reported; 75 per cent of these were over fifty when the diagnosis was made.

Cervical involvement is more common in the female, distal involvement more common in the male.

Squamous cell carcinoma is the type usually found, since the mucosa is squamous in type and is usually highly undifferentiated. Adenocarcinoma can occur in the distal one-third where mucous glands are present. How long it may persist without extension or metastasis is not known. Stenosis and stricture are frequent. Perforation into the trachea or a bronchus occurs but is unusual.

The differential diagnosis includes: diverticulum, foreign body, achalasia, idiopathic stricture, and extrinsic pressure.

Surgical management, which is the only hope of cure, is most adequately outlined by R. H. Sweet.[29] His publication indicates the procedure found most effective for the section involved.

Patients who have inoperable lesions can at times be kept relatively comfortable by repeated esophageal dilatations, although gastrostomy may have to be done.

While it is not entirely new, rotation therapy, the "spit" technique, or as it is currently called, "the merry-go-round" roentgen ray therapy has definite palliative value.[31] About 25 per cent so managed were alive after one year, and more than 15 per cent were alive after two years. Its greatest palliative measure is in restoring the ability to swallow by reopening the lumen of the esophagus. Once the problem of avoiding overdosage is removed and there is more accurate basis for calculating the depth dose, this form of therapy may offer even more than at present.

Caustics and Cicatricial Stenosis.—Chemical burns of the esophagus with their resultant residuals of stricture are fortunately only about one-tenth as common as they were prior to legislation requiring the proper labelling of caustics. Aside from the occasional suicide attempt, which is rarely successful, these usually occur in children under five who come from poorer families.

The immediate care of the victim is to give vinegar to neutralize caustic alkali (sodium hydroxide) and sodium bicarbonate to neutralize acids. Following this, treatment of the local reaction in the mouth and esophagus is necessary. This may be done by the administration of repeated doses of olive oil or of bismuth subcarbonate powder. Fluid intake must be maintained at a high level. Perhaps the most effective management, from the standpoint of preventing stricture, is that outlined by Salzer,[20] ably summarized recently by Hanckel.[3]

After initial neutralization, a Levine tube is in-

serted and left in place until peroral bouginage is begun, usually in two or four days. Gastric lavage may be carried out through the tube and may prevent pyloric stenosis. After allowing time for the acute phase to subside, dilatations from above were done, usually blindly, employing mouth gag and restraints on the child. At present, however, there seems to be another possibility with the advent of the Tucker indwelling cannulated bougie.[31] This may be placed at the time the cicatrization is developing. The length of the bougie is such that it will pass into the stomach of the child. The upper end should be suspended in the esophagus so that the slender tip and suspension string only are above the cricopharyngeus. Severe stenosis seldom occurs above the level of the suprasternal notch, and the opening in the bougie permits fluids from the mouth to pass into the stomach through the strictured area when the bougie is properly placed. Tucker recommends the bougie to remain in the stenosed area six to twelve hours. Bougie size increases as the stenosis decreases. The one serious drawback to an indwelling bougie, damage to the larynx, should not occur with this type bougie, since only the tip should be in the hypopharynx. Additionally, the Tucker cannulated bougie allows the saliva to pass through the central canal of the indwelling tube, and as the stenosis is dilated, saliva also passes around the tube. The major objection to this method is the fact that this bougie has to be passed blindly.

In severe burns gastrostomy may have to be performed, giving the esophagus complete rest and allowing proper nourishment. After the acute phase, the patient is given a heavy silk string to swallow, and retrograde dilatations with the indwelling cannulated bougie are begun. This can be done perorally, also, and may be easier for the patient. While many clinics prefer gastrostomy and retrograde dilatations for an already developed stricture, this clinic has found that the passing of a fenestrated bougie over a string, perorally, has been very effective and without risk. This procedure is done weekly, on an outpatient basis, the patient swallowing three to five yards of string beginning twenty-four hours prior to the appointment and reporting for passage of a Plummer-type of dilator over the string into the stomach at weekly to monthly intervals, until dilatations reach 45-F and the patient is able to manage dilatation with the Hurst mercury dilator, 44 to 45-F, at home. The one contra-indication seems to be a previously present gastroenterostomy.[22] The patient should be recalled at six-month intervals after this point has been reached, for a barium swallow to check the area of stenosis.

Cardiospasm (Achalasia).—This is a fascinating disease in which there is tremendous dilatation of the thoracic esophagus of insidious onset due to long delay in opening of the hiatal closing mechanism. No conclusive contributions have been made in recent years which would clarify understanding of the cause of the condition. Alvarez many years ago suggested a simple cause of the dysfunction. He felt that an absence of ganglion cells between the coats of the esophageal muscle is a common finding. This, however, would indicate previous toxicity, relatively severe, that is not always substantiated in the history.

A recent survey of this entity showed it to occur in about one case in 3,000 clinic patients, equally divided in the sexes, occurring in the third or fourth decade, abruptly in some, insidiously in others. The most common symptoms are[24]:

1. regurgitation of ingested food
2. sensation of food sticking as it reached the lower end of the esophagus, mostly solids, but in 50 per cent both solids and liquids, and of the latter, cold more than hot
3. pain or discomfort between throat and upper abdomen (less marked in well-established cases)

As indicated, the cause is not clear and associated carcinoma is uncommon.[5] In about 50 per cent it followed surgical procedures. An attempt to explain its etiology is further complicated by the lack of unanimity relative to the presence of a sphincter at the esophago-gastric junction. Some experimental observations on patients with cardiospasm[17] indicate that as a group they are dour, humorless, wary, suspicious, noncommital and defensive. In short, in their attitudes and behaviour they are ruminative, and rumination is suggested by their esophageal dysfunction. Various attempts experimentally on the clinical level fail to show that the cause may be Vitamin-B lack. Cardiospasm is not, morever, a manifestation of beriberi.

The diagnosis is made by esophagoscopy and esophagrams.

To review esophageal peristalsis briefly: true primary waves of esophageal peristalsis initiate in

the pharynx and pass along the esophagus propelling the food bolus. The cardia relaxes with the approach and reflex stimulation of this wave. In cardiospasm these are absent and segmental waves, non-peristaltic in type, are present. These are called tertiary waves. These may actually be seen in the elderly without cardiospasm. However, in the typical cardiospasm case the primary wave, under the fluoroscope, will be seen to end at the suprasternal notch and below this segmental (tertiary) waves begin with cessation of progressive peristalsis and barium passing upward and downward without purpose. Primary waves do not return even with clinical improvement of symptoms. In many cases an apparently adequate esophageal channel exists in the cardiac area. The difficulty lies in the absence of rhythm and regularity in its opening. Right oblique x-rays in most patients will define the point of constriction. In about 55 per cent the obstruction is above the diaphragm; 28 per cent at the level of the diaphragm and about 15 per cent below the left leaf of the diaphragm.

The chief differential is carcinoma.

The complications of cardiospasm are multitudinous; regurgitation pneumonitis, basal pneumonitis, lung abscess, pleural effusion and bronchiectasis may complicate. Fifty per cent will have chronic respiratory symptoms, such as cough, dyspnea, chills and fever. A fair number complain of asthma and hay fever.

The majority have a fairly marked weight loss.

Regurgitation of blood rarely occurs and tarry stools are rare; about half are constipated. Anemia in an insignificant finding. There is no consistent relationship to body types or to the use of alcohol or tobacco.

Until recently medical treatment has been of no value and the patient was dependent for relief upon either dilatation or surgery. The recent method of Balfour and Wharton[1] shows considerable promise in a number of cases. A paste made with a dram of 2 per cent procaine and a dram of metmucil in 2 to 3 ounces of water, is given one-half hour a.c., t.i.d. The effect lasts one and one-half to two hours. This program is followed for four to six weeks and has produced relief of symptoms, although not always a change in the x-ray.

Of those not responding to the above medical treatment, the majority show satisfactory results with dilatation using the mercury filled dilators of Hurst or others such as the mercury filled pneumatic bag of Browne-McHardy, or hydrostatic dilators. There is an ever present danger of rupture of the esophagus and diaphragm, but this is rare. Most require over five dilatations. About one-third experience moderate to severe chest pain with dilatation. The period of relief varies from hours to weeks or months. A satisfactory result means only slight dysphagia not interfering with effective swallowing.

Surgical treatment is indicated only when medical treatment or dilatation, which is about 85 per cent effective,[23] fails. Operation does not restore primary waves but is done essentially to relieve the terminal obstruction. The procedures used are: esophagogastrostomy, cardioplasty, and extramucous esophagocardiomyotomy, similar to Ramstedt's operation for infantile pyloric stenosis which is currently achieving popular favor. Hoover[4] reports seven cases in which cardiectomy with removal of some portion of the stomach and esophagus has been carried out for "the relief of a benign condition, stricture, fibrosis or cardiospasm" with good results.

Using the Hurst bougies dilatation is begun by passage prior to each meal, the interval lengthened as the symptoms improve, and omitted with the symptoms completely relieved. Hurst recommends leaving the bougie in place for fifteen minutes. The ability of the patient himself to manage these recommends them highly.

Diverticulum.—The diverticulæ of the esophagus have been classed pulsion, traction and congenital. By virtue of the degree of protrusion they are classed true or false. If all layers of the wall are involved it is a true type; if but part, then a false diverticulum. They are usually true and rarely congenital although a congenital weakness is probable.

Diverticulum of the hypopharynx really should be considered as a different problem than that of diverticulum of the esophagus. It is a false (Zenker's) type of deformity composed of mucosa and submucosa herniating through the zone of the junction of the pharynx and esophagus and through the triangular space bounded by the fibers of the cricopharyngeal muscle and the inferior constrictor of the pharynx. The position of the sac may be in the midline or, usually, to the left between the two muscles.

Various methods for the division of the partition between the pouch and esophagus, the inversion, transplantation or rotation of the sac without removal have been found to be unsafe or unsatis-

factory and should not be used.[11] Resection of the sac by the one stage operation has proven to be safe and effective in eradication of the condition.

Patients with this type deformity present themselves with progressive dysphagia, regurgitation, belching and pressure in the neck. Many of them have cough or excess saliva, and complain of choking and gurgling sensations in the neck. It is predominantly a disease of males between the third and sixth decades. Tumor is prominent in some and may produce hoarseness and a Horner's syndrome. Inanition may develop from obstruction in the absence of infection.

The diagnosis is made by esophagrams.

The thoracic esophagus is the site of the traction type and there is frequently the history of tuberculous adenitis, mediastinitis, adhesions and finally the formation of a tent-like diverticulum with a wide neck and a narrow everted fundus. The diverticulæ vary in shape but the neck and fundus are usually of the same size or nearly so. They are generally found in the elderly. X-rays are best taken in the left oblique position. These are first seen as the bolus passes. A small amount of barium remains for a brief period at the defective spot. The important thing is whether or not they retain barium very long. If they do, they are potentially dangerous. The symptoms are usually mild and rarely justify thoracotomy. The chief complaint is of pain behind the sternum or in the back or in the epigastrium, although many are without symptoms of any kind.

Congenital Stenosis.—Congenital stenosis of the esophagus is rarely a distinct entity. The most common malformation is obstruction, the lower end of the esophagus[10] communicating with the trachea at the bifurcation.

Complete stenosis is not compatible with life, usually, although gastrostomy and repeated procedures to establish drainage of the upper esophagus externally and modern methods of reconstructive plastic surgery may offer some help.

Congenital Artresia with Tracheo-Esophageal-Fistula.—This is a condition now meriting more consideration since the successful work of Leven[11] and Ladd[10] in 1939. Ladd gives five possible anomalous forms:

1. the upper esophageal segment ends in a blind pouch in the upper third and the lower esophagus segment is represented by a similar blind pouch.

2. the upper esophageal segment communicates with the trachea and the lower segment is a blind pouch.

3. the upper segment terminates blindly and the lower segment is in communication with the trachea above the carina.

4. this is similar to three except that the lower segment communicates with the trachea and the carina and the right or left main bronchus.

5. both segments communicate with the trachea.

From a practical standpoint about 75.12 per cent find the upper esophageal segment ending blindly and a lower segment communicating with the tracheobronchial tree by means of a fistulous tract.

The diagnosis is suggested by increased oral secretions, regurgitation and attacks of cyanosis. Diagnosis is established by passing a small catheter into the esophagus and failing to meet the stomach. Under fluoroscopy, 1 cc. of lipiodol is instilled into the catheter demonstrating the upper segment with or without the tracheoesophageal fistula. During and between swallowing under fluoroscopy the inferior level of the upper esophageal segment is noted. Then the lipiodol should be aspirated. The chest and abdomen should be x-rayed to determine the pulmonary status, the presence or absence of gas in the gastrointestinal tract and possibly reveal other anomalies. Gas in the gastrointestinal tract is usually indicative of a fistula.

Needless to say, definitive surgery, obliteration of the fistula and establishing a passage to the stomach is the only treatment.

Esophageal Varices.—Varices occur in cases of Banti's disease and in association with other maladies. They are obstructive, producing symptoms when they are large. The veins of this region are a part of the anastomosis between the portal system and the vena cava. Any obstruction to the portal or caval circulation naturally causes back pressure and varices are enormous. Thinning of the walls may cause hematemesis or fatal hemorrhages.

Esophagoscopy, carefully and gently done—as it always should be—will establish the diagnosis. If in a quiescent stage an esophagram will give the characteristic "beaded" appearance near the hiatus. If asociated with cirrhosis, liver function tests will be positive.

Treatment in hemorrhage is by bismuth subnitrate given dry on the tongue, 4 gm. every hour

for three doses, then less frequently. Rest and transfusion are usually essential. Of recent vogue is the use of balloon tamponade in the management of the hemorrhagic episode. The results of this type of therapy ore not yet well evaluated but offer considerable promise. Morphine should not be used because of its nauseating properties.

This manifestation of esophageal disease is a serious problem in areas where Manson's schistosomasis is endemic. This disease kills one of four patients with bleeding from esophageal varices. Esophagoscopic injection of sclerosing solutions to obliterate the varices has been reported[14] to be a life-saving measure. Using 5 per cent sodium morrhuate and injecting 1.5 cc. at intervals of a few days seems well tolerated and prognostically is more effective than splenectomy, although it is not unattended by the danger of severe hemorrhage.

The surgical measures such as the portal-caval shunt in the management of cirrhosis seem to offer some hope. Packing of the mediastinum, modifications of the "Ech" fistula for cirrhosis and ligating of the hepatic artery have been insufficiently tested to evaluate.

Scleroderma.—Diffuse scleroderma has as sites of predilection the limbs, face, and upper body. The face may become masklike and expressionless, and the hands assume a clawlike appearance. There are respiratory and swallowing disturbances. From studies of patients with the disease[9] about 50 per cent complain of dysphagia. All patients in which the esophagus was examined with barium under fluoroscopy, dilatation with absent peristalsis was noted in three of four of them. In a fourth case peristalsis was absent and there was stasis, but the calibre of the lumen was normal.

Treatment of this symptom in scleroderma is symtomatic and consists of the administration of PABA or, more recently, ACTH and Cortisone.

Plummer-Vinson Syndrome.—Sir Arthur Hurst[6] states he was the first to label upper dysphagia with anemia "Plummer-Vinson syndrome" because of Vinson's paper in 1922 referring to the unpublished work of Plummer in 1914. However, he feels now more appropriate is the "upper dysphagia with anemia syndrome of Paterson." This is also commonly designated as the sideropenic anemia with dysphagia. It occurs in 15 per cent of the simple hypochromic anemias as a disease of women between the ages of thirty and fifty and is due to iron deficiency. It causes anemia and atrophy of the mucous membrane of the tongue and pharynx, and results in loss of sensibility so that the afferent side of the reflex, upon which the second stage of swallowing depends, is impaired. Termed by Vinson[34] "the only true type of hysterical dysphagia," fear of choking interferes with normal swallowing and an unbalanced diet leads to secondary anemia, splenomegaly and nutritional changes of the mucous membrane of the tongue and corners of the mouth.

The differential diagnosis of this relatively rare disease from functional dysphagia is quite simple. The latter is lacking in atrophic changes in the pharynx and anemia is not necessarily a part of the syndrome, and it is essentially a syndrome of a younger age group with many situational anxiety problems. There are numerous reports in which a provisional diagnosis of Plummer-Vinson syndrome has not been substantiated by esophagoscopy. The findings in many cases are those of upper esophageal web formation.[30]

There is a high frequency of carcinoma occurring at the esophageal introitus, in cases of Plummer-Vinson syndrome.[28] Simpson,[26] in discussing it as a precancerous condition reported carcinoma developed in ten of eighteen patients with this syndrome.

Treatment of this syndrome is the treatment of the iron-deficiency anemia by replacement therapy, following substantiation of the diagnosis by esophagram, esophagoscopy and blood counts.

Angioneurotic Edema, et cetera.—Angioneurotic edema, urticaria, serum diseases and herpetic lesions are all known to produce dysphagia in some cases. In some they will produce complete esophageal obstruction.[7] Along with the dysphagia there may be a complaint of painful swallowing (odynophagia) and retrosternal or mid-back pain.

After the history of an allergic type response is obtained, diagnosis is made by esophagoscopy.

Our management of these syndromes, now more effective than in the past, is by the use of antibiotics, intramuscular or intravenous antihistamines, and, more recently, by ACTH.

II. Functional Dysphagia

Globus Hystericus.—Globus hystericus, as we chose to label functional dysphagia, is the most common finding in the average case presenting it-

self to the clinic with the complaint "difficulty in swallowing." On taking an unhurried and sympathetic history, however, their story becomes one of a "lump in my throat that won't come up or won't go down." This complaint, however, is only constant with saliva and is almost always relieved by swallowing liquids or food. For this reason the patient is usually well-nourished and may actually have gained in weight since the onset of this symptom, since eating gives him relief. It shows a high degree of predilection for those whose daily duties allow them little expression and compel them to accept a high degree of abuse. They live, as Walden puts it, in a state of quiet desperation. Beauty shop operators, salesladies and housewives, admittedly dominated and unhappy, rank high in this group.

As noted previously, this must be differentiated from Plummer-Vinson syndrome. In most cases, reassurance and psychotherapy in the form of a sympathetic ear will resolve the syndrome. If cancerphobia or other neurotic elements are prominent, esophagrams and esophagoscopy are frequently employed to substantiate the clinical reassurance that cancer is not in the throat.

III. Extrinsic Causes

Hiatal Hernia.—Esophageal hiatal hernia and the problem of the congenitally short esophagus, their incidence and management, is most ably reviewed by Olsen and Harrington[19]:

Of their 220 cases, 141, or 64 per cent, were males, and seventy-nine, or 36 per cent, females. Only 11.8 per cent were under forty years of age. The largest number, seventy-two, were in the fifty to fifty-nine age group, although sixty-three or 28.6 per cent were in the sixty to sixty-nine group.

The symptoms most commonly present in their series were:

1. dysphagia .....165 or 75 per cent
2. substernal distress..... 71 or 32 per cent
3. esophageal pain..... 20 or 9 per cent
4. hemorrhage ..... 18 or 8 per cent
5. asymptomatic .....17 or about 8 per cent

Other conclusions they reached in their study were, summarily, (a) The true congenital short esophagus is rare but the acquired short esophagus of later life is not so rare.

(b) Congenital enlargement of the esophageal hiatus and atrophy or weakening of the diaphragmatico-esophageal membrane are basic to development of hiatal hernia. (c) Peptic ulceration of the esophagus will result in its shortening. This may result from excess vomiting or an incompetent sphincter. (d) Dysphagia is the most common symptom of the short esophagus. In its early stages spasm is present. Organic stenosis of the esophagus develops later. (e) Hiatal hernia of the short esophagus type is not favorable for surgical repair, but does respond well to medical management and esophageal dilatation.

Since the hernia of the normal esophagus is amenable to surgery careful differentiation is important, and is dependent upon careful x-ray and esophagoscopic study. The x-ray diagnosis of hiatus hernia is based on the exact location of the esophagogastric junction above the diaphragm or the recognition of a sacculous protrusion of the cardia above the diaphragm. The examination is best conducted with the patient rotated obliquely with the right side forward about 30 degrees while drinking thick barium. The demonstration is more apparent with the stomach full and the patient in Trendelenberg.

Medical treatment is directed toward symptoms due to the mechanical nature of the hernia.[25] The nature and cause of his condition is carefully explained to the patient. He is advised to avoid coarse, rough foods; to masticate properly and slowly; to eat frequent small meals, and not to lie down for at least an hour post sibum. Nocturnal eating is discouraged. Sleeping with the head well elevated may avoid sleeping problems. Antacids, antispasmodics and sedatives are useful.

Surgical care should offer a complete cure but most authors agree it is seldom necessary. It is a formidable procedure for an older age group. Surgery is perhaps best indicated for patients who have had repeated serious bleeding, for patients who are seriously disabled by pain or other symptoms not responding to medical treatment, for those in whom symptoms and signs may be confused with associated or complicating conditions in the region of the hernia which of themselves require surgical treatment. The results of surgical correction are uniformly reported as good.[27]

Aberrant Vessels.—Dysphagia due to unusually placed vessels is necessarily rare. Dysphagia lusoria, that due to an abnormally placed right subclavian artery, is the only one distinguished by a name. However, the aortic ring type and the mitroaortic in which a band surrounds either or both the mitral and aortic orifices are recognized.

Dysphagia, rather than cyanosis, may be outstanding and may be recognized by the rapid malnutrition of an infant. This may not appear until the infant is begun on solid and semi-solid food. Some of the food passes down but some stays in the pharynx or overflows. The child may make several attempts to swallow, then refuse.

Diagnosis is made by x-ray and cardiac catheterization.

A barium swallow will outline an indentation in the posterior wall of the esophagus, and injection of lipiodal into the trachea shows constriction of the anterior lower portion. Roentgen examination is essential to differentiate the condition from a mediastinal tumor or cyst.

The types of vascular anomalies encountered[2] are:

1. Double aortic arch produced by bifurcation of the ascending aorta. One limb passes anterior to the trachea, the other behind the esophagus. Both, then, are enclosed in a vascular ring which may narrow the lumen.
2. Right aortic arch associated with a left ligamentum arteriosum may form a ring compressing trachea and esophagus. Division of the latter relieves the compression.
3. Aberrant subclavian artery that branches from the distal part of the aortic arch instead of from the innominate artery. Ligation and division is the management.

Outside Pressure.—The most frequent lesions are:

1. Goiter, cervical or thoracic
2. Intra-thoracic tumor
3. Aneurysm
4. Cardiac or aortic enlargement
5. Hodgkins, or other adenopathies, et cetera
6. Lordosis
7. Enlargement of the left hepatic lobe

The treatment rests on the degree of involvement. Usually medical management with careful dilatation is adequate, if compression impairs nutrition. Diagnosis must be attained with the aid of x-rays, biopsy and esophagoscopy, except in aortic aneurysms. Laryngeal paralysis due to compression on the left laryngeal nerve may be associated, as in a recent case seen by us in which the first symptom presented by a teen-aged boy was dysphagia with liquids, followed by left laryngeal paralysis which brought him to the clinic because of his weak voice. X-rays revealed a large mediastinal mass, later proven to be a lymphoma.

IV. Inflammatory Lesions

Esophagitis.—In either the acute or chronic type of esophagitis, dysphagia is considerable. There will be a sudden onset of this symptom if due to trauma or ingestion of a severe irritant due to the edema which is produced. It will persist until the edema has receded. The patient may complain of painful swallowing, pain in the chest, have accompanying symptoms of lower intestinal involvement. While the esophagus remains the enigma of the intestinal tract, it is becoming more apparent that symptoms once thought to be reflex from peptic ulcer, et cetera, may well be incident to esophageal inflammation *per se*. Substernal discomfort, belching, heartburn, sense of fullness in the chest, et cetera, are being noted as related to small discrete lesions by the endoscopist. Smears or biopsy of the ulcerations found at esophagoscopy will differentiate it from malignancy and identification of the organisms facilitate its resolution by antibiotics.

In the acute phase, aside from specific antibiotics, the bismuth marshmallow for children and the bismuth subcarbonate powder for adults seems the best management. The latter is given in gram doses every three to four hours. Antacids, antispasmodics and a bland diet are symptomatic medications.

Following the acute stage and a symptom-free period, a chronic esophagitis may ensue. Since this pathology, if not halted, results in fibrosis and/or stricture formation, dilatations may become a necessity.

Tuberculosis.—Tuberculosis is an extremely rare primary lesion. The secondary type is diagnosed by smears, cultures and biopsy. Treatment is general, not local.

Syphilis.—Syphilis, too, is a rare inflammation but may be manifested in primary, secondary, or tertiary lesions. It is diagnosed not by Wassermann but by biopsy. Treatment is general.

V. Neurological Lesions

Myasthenia Gravis.—Myasthenia gravis is a somewhat rare disease, still not definitely described as to morbid anatomy, characterized by a weak-

ness of muscular action due to excessive or pathologic fatigue. Dysphagia is a prominent symptom and the presenting symptom in 20 per cent of the cases. One of the more common diagnostic signs is the so-called "vallecular sign." It implies the retention of barium in the valleculae and in the pyriform sinuses at the time barium visualization of the esophagus is being done. The standard treatment in this disease has been the use of 15 mg. tablets of prostigmine bromide. Surgery, in the last ten years, has offered some promise. At Massachusetts General Hospital, Viets[32] reports thirty-six patients subjected to thymectomy. Seven had thymomas, and twenty-nine showed various degrees of involution and the formation of germinal centers in the thymic tissue. Patients are adequately maintained on oral neostigmine, prior to surgery, and intravenous neostigmine at surgery. Viets concludes that the results justify the continuation of the operation and that the mortality should be close to zero if patients are well selected and maintained during surgery.

Jugular Foramen Syndrome.—The jugular foramen syndrome, first described in the French literature in the early 1900's, is one of involvement of the last three or four cranial nerves. In 1917, Villaret used the term "The syndrome of the retroparotid space" a syndrome of homolateral paralytic association of larynx, soft palate, tongue and muscles of the neck, particularly the sternocleidomastoid and trapezius.

A similar syndrome may result from accident or gunshot wound, and surgical correction, if the seventh nerve is not involved, has been described.[16]

The jugular foramen syndrome may, in fact, be caused by any tumefaction near the jugular foramen but in our series, and in a recent revision of pathological diagnoses, the glomus jugulare tumor is not a rare cause of vagal disturbances manifested in part by dysphagia. The surgical treatment of this extremely vascular tumor is risky and difficult. Its response to irradiation therapy is not too clear.

Multiple Sclerosis.—Multiple sclerosis is characteristically irregular in its symptom syndrome and dysphagia is an incidental and infrequent symptom.

Progressive Bulbar Palsy.—Progressive bulbar palsy (progressive-glosso-pharyngolabial) is an uncommon disease of later life with a lower motor neuron symptom complex and associated atrophy of the muscles of the tongue, lips, jaws, larynx, and pharynx. It ends fatally and no known treatment is effective.

Pseudobulbar palsy presents the same symptom syndrome as does the previous disease but there is no associated atrophy.

Acute Poliomyelitis, Bulbar Type.—Acute poliomyelitis, bulbar type, quickly presents a child who is having increasing dysphagia, nasal voice and the accumulation of saliva and mucus in the throat. Attempts to drink fluids causes coughing and choking. These symptoms are usually followed by coma, respiratory arrest, et cetera. The use of the respirator, early tracheotomy and supportive care are important.

Thrombosis of the Posterior-Inferior Cerebellar Artery.—Thrombosis of the posterior-inferior cerebellar artery is an uncommon condition characterized by hemi-ataxia of the homolateral limbs plus loss of sensibility to pain, heat and cold on the contralateral side. This produces a definite but temporary dysphagia.

It seems in order here to note that a difficult problem may present in the newborn because of neuromuscular incoordination. Symptoms of tracheo-esophageal fistula in a newborn not corroborated by the radiologist may be due to temporary and partial bulbar palsy. Forceps delivery and prolonged second stage of labor may suggest this possibility. The child will swallow poorly, regurgitate, aspirate, and be moderately cyanotic.

Evidence in the literature earlier suggests that immaturity of the medullary centers may be responsible.[13]

Other Diffuse Central Inflammations of CVA's.—Serious infections which have marked central nervous system disturbances and produce dysphagia are, of course, important by virtue of their primary nature. The feeding problems incident to them are well-known and treatment well standardized.

Summary

An attempt has been made to assemble all the data necessary for the physician to make a differential diagnosis on dysphagia. Prevailing surgical procedures and medical management are outlined.

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The Problems and Management of the Fractured Hip

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FOR THE past fifteen years most orthopedic and traumatic surgeons have agreed that open reduction with internal fixation is the treatment of choice for the elderly patient with a fractured hip. There are still a few orthopedic surgeons who prefer to use well-leg traction, Roger-Anderson's pins or the Whitman abduction method with plaster of paris spica, as therapy for the debilitated person. It is their belief that such people will not tolerate the trauma of surgery.

The primary purpose of this paper is to present the problems and management of the fractured hip in the elderly patient, who is not only debilitated but is also a so-called poor surgical risk. The following series will show that this type of patient is best handled by early open reduction with internal fixation, along with early discharge to their own home and family.

Obviously, the preferred treatment is that method which provides the best answers to the problems which are common to all cases of hip fractures in the debilitated geriatric patient. First, it is the duty of the surgeon to provide maximum comfort and relief of pain to these people. This is accomplished by immediate proper traction and early open reduction with internal fixation of the fracture. It is important to minimize senile psychosis and degeneration. To that end, it is imperative to reassure the patient that he will return home to his family within a few days and that he will be able to walk again. It goes without saying, that we are obliged to minimize morbidity and mortality, to obtain bony union and good functional results as well as decreasing the economic burden to the patient and the patient's family. It is also necessary to prevent the complications to which these patients are prone, including decubitus ulcers, vascular changes, stiffness and contractures of the knee, thrombosis, and pneumonia. These problems are best answered by early open reduction with internal fixation along with early discharge to home.

As soon as the patient with a fractured hip is admitted to our hospital, a complete history is taken and a thorough physical examination performed. Immediate therapy of associated disease is begun. In our series the most prevalent diseases were rheumatoid arthritis, diabetes mellitus, cardiac decompensation, bronchiectasis, cerebral arteriosclerosis, emaciation, cystitis, and hemiplegia. It is necessary to prevent prolonged preoperative preparation of the patient. Our observation showed that most of these patients began to deteriorate after forty-eight hours. Thus, we operate upon all fractured hips within two days unless there are some definite contraindications.

All patients are put in Russell's traction upon hospitalization. Russell's traction pulls down with abduction and is comfortable. It will reduce most fractured hips within twenty-four hours. It is to be noted that the position of the foot in Russell's traction is not a true indication of the position of the fracture. Perineal palsy is prevented by adequate padding of the hammock. An indwelling catheter is inserted in most cases to prevent bed soiling and bladder distention.

Preoperatively our patients receive morphine, gr. 1/8, or codeine, gr. 1, along with atropine, gr. 1/200. All of our patients receive avertin as a basal anesthetic. The amount is indirectly proportional to the patient's age and physical condition. Generally, a sixty-year-old patient receives 60 mg. of avertin per kilogram of body weight, whereas a seventy-year-old patient receives only 55 mg. per kilogram of body weight. Using this dosage, avertin is a safe and effective basal anesthetic for the geriatric patient. It is supplemented by nitrous oxide and oxygen. The younger patients occasionally receive ether. Deep anesthesia is not necessary or indicated for the elderly patient with a fractured hip, and we have had no anesthetic complications or deaths using this regime.

The patient is placed gently on an orthopedic table. The patient is horizontal with the leg in light traction, moderately forceful internal rotation, slight hip flexion and gentle abduction. This secures the best reduction except for certain types of intertrochanteric fractures. A preoperative x-ray of the hip is taken. We have minimized the time needed to obtain the radiograms, by having well

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trained technicians utilizing hot developing solutions in a darkroom adjacent to the operating room.

Generally the type of internal fixation which is most desirable can be determined before the incision is made. In most neck fractures, and the majority of poor risk patients, or bedfast patients, a Smith-Petersen nail is used. In other patients with intertrochanteric fractures, we have utilized a Jewett, Neufled or McLaughlin nail. The Moe plate with transfixion screws is used when the fracture is severely comminuted.

One of the most important factors in operating upon the debilitated geriatric patient is to avoid unwarranted prolongation of anesthesia, shock and surgical trauma. This is accomplished by administering intravenous fluids and blood, but most of all, by the co-operation of a well-trained surgical team.

The surgeon must determine the individual angle of the neck which is done by x-ray, manual palpation, and direct visualization, if necessary. One must be sure that impaction is complete and that anatomical reduction is good. This position is held by leaving two guide wires in place until fixation by the nail is secured. The proper length nail can be determined by the x-ray of uniform guide wires of constant length. In most instances, the proper position of the nail is so that lateral x-ray view shows the nail through the center of the neck and in the lower part of the neck in the anteroposterior view, and placed not closer than 1 cm. to the articular surface of the femoral head. Other positions predispose to coxa vera and later perforation of the femoral head.

The next group of problems concern themselves with the prophylaxis of postoperative complications. Morbidity has been definitely reduced by the routine administration of penicillin for the first three postoperative days. Postoperative shock is prevented by using a minimum of preoperative medication, anesthesia, and operating time, along with the gentle handling of the patient. Overhydration is avoided by giving no saline the first forty-eight hours and giving only 500 cc. of intravenous fluids at one time, and never to exceed 2,000 cc. in twenty-four hours. It is necessary to educate the nursing staff so that nursing errors such as the twisting of the leg, causing external rotation, along with possible injuries to the spine or hip, can be avoided. Drug idiosyncracies must be kept in mind when the patient exhibits postoperative psychosis. We also routinely allow most patients to be taken about the floor in a wheel chair on the second or third postoperative day. It is also helpful to allow the geriatric patient to return to his lifelong habits as soon as desired. The patients are encouraged to eat a high protein, high vitamin diet. We discharge the patient as soon as practical, and it is our feeling that the elderly patient does better in his own home with his own family. Expenses, as well as nursing care, are a real problem in the hospital.

The last group of problems to be considered are the delayed complications including coxa vera, hip and low back pain, migration of the nail or fragments, and delayed union.

Coxa vera cannot be entirely eliminated. It is usually due to absorption at the fracture site or the comminution of the fracture with upward progress of the trochanter and fragments. Coxa vera can be minimized by obtaining good impaction; the proper placing of a nail which will not bend, and by forbidding early ambulation.

Hip pain is a common complication following open reduction with internal fixation. Among the common causes of hip pain are aseptic necrosis, medial migration of the nail, and arthritic changes.

Aseptic necrosis will always occur where the blood supply has been destroyed at the time of injury. Postoperative aseptic necrosis is to be suspected in patients who have groin pain during the first few days after surgery. It is our impression that the incidence of aseptic necrosis is higher in those patients who had a Moreira nail fixation. We believe that the Moreira nail causes increased destruction of the blood supply to the neck of the femur, and that this type of fixation allows for rotation of the femoral head after bone absorption. We agree with other authors that early ambulation predisposes to aseptic necrosis. Therefore, we allow no ambulation for three months and no weight bearing for four months, or until the x-ray shows good callus formation.

Medial migration of the nail is not preventable when it is attached to the femoral shaft. It is due to bone absorption at the fracture line, and must be taken into consideration when the nail is inserted. If the hip remains painful, the nail may be removed, after adequate callus formation. Bone absorption is also responsible for medial migration of the distal fragment. Some orthopedic surgeons believe that the Moreira nail prevents this complication.

The incidence of delayed union can be decreased by securing good impaction and anatomical reduction. It is also important to avoid early ambulation and weight bearing by the injured hip.

Following hip fractures many patients develop a clinical shortening of the affected leg. Usually it is minimal and is compensated by a tilt of the pelvis. If the condition is responsible for back pain, an orthopedic shoe with an elevated heel may be prescribed.

There will always remain some patients with a painful hip, that cannot be explained by x-ray. Occasionally a patient is sensitive to the metal and removal of the nail will give relief.

The following statistical report concerns 225 private patients with fractured hips who were treated by open reduction with internal fixation at the Leila Y. Post Montgomery Hospital in Battle Creek, Michigan, between 1946 and 1952.

The preoperative and postoperative care, as well as the surgery, was performed by our orthopedic surgical team which includes the resident staff. Thirty-six per cent of the entire series were operated upon by the surgical residents under the personal supervision of the attending orthopedic surgeons.

The age of the patients varied from twenty-eight to ninety-nine with an average age of seventy-three. Nine patients were under fifty years of age. Of these nine, seven received fractured hips as a result of automobile accidents. There were forty-two men, or 18.2 per cent, and 183 women, or 81.8 per cent.

Two patients had advanced rheumatoid arthritis, seven had diabetes mellitus, thirty-seven had cardiac decompensation, two had marked bronchiectasis, twelve had advanced cerebral arteriosclerosis, and ten were hemiplegics. Therefore, it is quite obvious that many were geriatric patients who were a so-called poor surgical risk. Only one patient was not considered surgical. She was eighty-four years old and was admitted with terminal pneumonia. She expired four days after hospitalization and is not included in this series.

The type of injury is of some interest. One patient jumped from the second floor of a burning house. Seven were in auto accidents, eight fell down the stairs, and 209 had simple falls with torsion. Of these patients, 118, or 56.9 per cent, had an intertrochanteric fracture, that is, a fracture located from the extracapsular portion of the neck to a point 5 cm. below the lesser trochanter. One hundred and seven, or 43.1 per cent, had a neck fracture.

The time from injury to surgery varied from nineteen hours to twelve days with an average time of 1.6 days. The patients with prolonged preoperative hospitalization were mostly the patients in automobile accidents who had multiple fractures and were considered critical for several days.

All patients were immediately put in Russell's traction. Avertin was given as a basal anesthetic in every case. The length of the surgical procedure varied from thirteen to 140 minutes with an average time of sixty-five minutes. The types of fixation were as follows: Moreira nail, thirty-two; McLaughlin nail, five; Jewett nail, thirty-five; Neufeld nail, fifty-seven; Moe plate with transfixion screws, two; Smith-Petersen nail, ninety-eight, three of which were with associated plates and seventeen were used in intertrochanteric fractures in bedfast or poor risk patients.

The postoperative morbidity as measured by an elevated temperature was from zero to six days with an average of 1.8 days. The length of hospitalization was from three to sixty days with an average of 9.2 days. One patient had a severely comminuted fracture which was impossible to reduce. She was in the hospital twenty-eight days. Four patients with multiple traumatic fractures were hospitalized sixty, twenty-seven, twenty-three, and twenty-five days, respectively. Excluding these five cases, the average length of hospitalization was 8.2 days.

In this series there was no hospital mortality. One hundred and eighty-seven or 83 per cent lived past the eight-week period, and fifty-six, or 25 per cent, were bedfast. We are positive that 100 per cent had less pain, senile psychosis, morbidity, mortality, and were a greatly decreased nursing and economic burden to their family. Office and clinical follow-up showed an estimated 20 to 33 per cent minimal coxa vera and a 5 per cent functional coxa vera. Only one hip was not reducible and two had a painful hip due to metal sensitivity. Aseptic necrosis appeared in 12 per cent of the neck fractures and four of those had Moreira nail fixation and early ambulation.

In conclusion, we desire to stress two points: (1) early open reduction with internal fixation is the treatment of choice for the debilitated geriatric patient with a fractured hip. (2) Morbidity and mortality are reduced by avoiding prolonged surgical procedures and hospitalization.

Delivery of Thoracopagus Twins

By Harvey C. Bodmer, M.D.

Kalamazoo, Michigan

THORACOPAGUS twins are an obstetrical rarity, particularly in the hospital of a small community. A pair of thoracopagus twins was delivered by Cesarean section at Borgess Hospital, Kalamazoo, Michigan, on March 11, 1952.

Case History

Case 150999.—M. B., aged nineteen, presented herself for only one prenatal visit late in the third trimester. The findings of the abdominal examination raised the question of twins. X-rays to confirm the diagnosis were suggested, but the patient refused. This was her second pregnancy, the first being an uneventful delivery of a normal child when she was sixteen. Her health had been good since that time. There was one set of normal twins in the family—born to an aunt of the patient's husband. There were no other multiple pregnancies on either side of the family.

The next contact with the patient was on her admission about 10:30 p.m. on March 10, 1952. She was actively in labor, 3 cm. dilated, with a double footling presentation. Hydramnios was present. The cervix became dilated to 8 cm. after two hours of moderately severe labor. The membranes were ruptured artificially and delivery was attempted. The delivery proceeded normally until the anterior double footling reached the bitrochanteric level of the fetus. At this point all progress stopped. A vaginal examination was done because of the hydraminos and the unusual findings on abdominal palpation. Examination of the anterior presenting twin, which was now in an OP position, revealed no umbilical union. The fetus did not present a head as expected. Upon re-examination of the sacral area of the anterior presenting fetus, arms and legs were found in their normal relationship. Examination of the abdominal side revealed a single umbilicus and umbilical cord, and it was possible to identify the approximate structure and position of a mouth. This later proved to be a harelip and cleft palate. The single umbilicus of the thoracopagus union had not been found on the first examination since the union extended further down than the umbilicus. Consultation with Dr. Frederick C. Ryan, Chief of Obstetrics, Borgess Hospital, was requested at this time, and the diagnosis of multiple birth and monstrosity was agreed upon. It was decided to deliver the patient by Cesarean section.

The parts already delivered, i.e., the lower buttocks and feet of the anterior presenting fetus, were sterilized and a classical section was done. A dead multiple thoracopagus twin pregnancy was delivered. The total weight was 11 pounds, 8 ounces. The anterior fetus was slightly larger, while the smaller or posterior fetus had a cleft palate, harelip and bilateral club feet (Figs. 1 and 2).

There was a considerable amount of jaundice-like stain on the mother's abdomen after delivery. The urine was tested for bile and porphyrins. The results were negative.

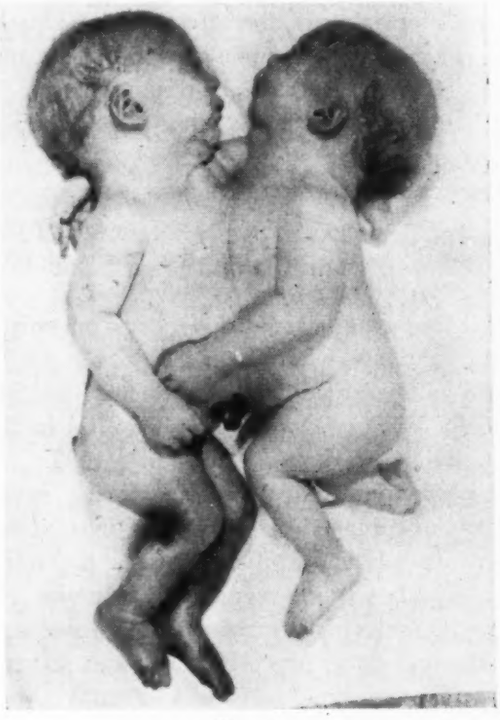

Fig. 1.

An autopsy was refused, but the placenta was sent to the pathology laboratory for examination. It was considered normal in shape and size with a battle-door implantation. It weighed one and one-half pounds.

Recovery was uneventful and the patient left the hospital on the fifth day.

Discussion

Thoracopagus twins, by definition, are twins joined in the chest by union extending from the approximate angle of Louis to the region of the umbilicus. The Greek word "pagus" indicates the union of the two pregnancies and the word "thoraco" indicates the location of this union. Such twins are classified by Patten as double monsters.[10] The incidence of this type of delivery is rare. In Cook County there was one case in 80,000 deliveries; and in New York Jewish Memorial Hospital there was one case in 11,970 deliveries.[11]

In the discussion of multiple births, it is interesting to note that there is a ratio of approximately 1 to 86 in the United States. In Great Britain the ratio is 1 to 80.[8] However, the incidence is less frequent in the Mongoloid races. The Japanese ratio is 1 to 145. Multiple deformities occur in a ratio

of 1 to 20,000-50,000 births. It is also interesting to note that the incidence of malformations is higher in the white race than in negroes, according to Murphy and Potter.[12] According to the work of

Fig. 2.

Newman, there are six to seven times as many stillbirths among monozygomatic twins as there are in single deliveries.[9]

The theoretical causes of these deformities are based largely on experiments done on fish. Landauer demonstrated that the number of deformities increased with the contamination of food or any exposure to insecticides containing selenium.[7] The possibility of manganese deficiencies was brought out by Caskey and Norris.[1] Werber showed the influence of bituric acid or acetone in double monsters.[13] Intercurrent infections as a cause of these deformities have been suggested.[5] Radiation may be a cause. However, in reviewing the history of this patient, nothing could be found that might have had an influence on this case and the cause of this double monstrosity, monozygotic pregnancy, remains unknown.

In multiple pregnancies the average gestation period is 255 days. According to the most accurate estimate possible in this case, the patient was due on April 15, but she delivered on March 11, after active labor. The weight, 11 pounds, 8 ounces, was slightly over the average of 5 pounds for each deformed fetus.

A case was reported in Florida in 1949 in which an antepartum diagnosis by routine x-ray was made and which resulted in an elective Cesarean.[4] However, the mortality of the double monstrosity in ten minutes and twenty-five minutes, respectively, gave no better results than a later diagnosis. In our opinion, to deliver a double monstrosity from below would be determined primarily by the location of the union.

The posterior cephalic delivery in the classical case of Chang and Eng, the original Siamese twins, was made possible by the sacral location of the union and its elasticity.[2] An anterior breech delivery is another possibility, but when the pagus is located in the flank, delivery from below is practical only by mutilation or when the fetus is extremely small. In a case reviewed and reported from Loma Linda, the delivery was accomplished only after mutilation and some evisceration.[3] Double decapitation, amputation at the pelvis and some evisceration was necessary in a case reported from Mombasa in Africa.[6]

In conclusion, the author feels that the diagnosis of a double monstrosity with an unknown union must depend largely on antepartum x-ray and on vaginal examination during active labor. Because of the high fetal mortality in this type of case, even under the most successful conditions, the condition of the mother is worth consideration. The Cesarean section is recommended in order to enhance her recovery and to reduce the morbidity and possible postpartum complications.

Acknowledgment

The author wishes to express his appreciation to Drs. John Hammer, Frederick Ryan, and Albert DeGroat, the Medical Library and Roentgenology Department at Borgess Hospital, and the Research Library of the Upjohn Company for their cooperation.

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Large Dermoid Cyst of Ovary Obstructing Birth Canal as a Complication of Pregnancy

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Munising, Michigan

THE purpose of this presentation is twofold. First, it disproves the adage that, "once a caesarian, always a caesarian," provided, of course, that the indication for the first section can be subsequently eliminated. Secondly, it emphasizes the importance of routine prenatal vaginal examination. Failure to make this examination would have proved rather embarrasing in this patient at the time of delivery, of the two pregnancies to be described.

Case 1.—Mrs. V. W., aged twenty-six, mother of one child six years old, presented herself in February, 1947, with the history that she believed she was about three months pregnant. Her first child was delivered vaginally without difficulty, and in the ensuing six years she had not been pregnant despite the fact that she had never used contraceptives. Physical examination was essentially negative except for the findings in the pelvis. A bimanual vaginal examination revealed an enlarged soft uterus about the size of a three months pregnancy, and in the pelvis was found a large, fixed mass, which was hard in one portion, and had a cystic character in the remaining portion. The impression was that the mass was an ovarian cyst which would render vaginal delivery impossible. The finding was explained to the patient, and surgery was recommended with the warning that the operative procedure might precipitate an abortion. As an alternative, it was suggested that an elective caesarian could be done and the mass investigated at the time of section. Since she was anxious to have a live baby, she chose to submit to a caesarian section.

On August 19, 1947, a classical cæsarian section was performed, and at operation a large cyst of the right ovary was found to be free and was removed. It was envisioned then that the cystic ovary that was felt at the first prenatal examination had risen out of the pelvis as the uterus enlarged in the ensuing months. The postoperative course was uneventful.

The patient was next seen on April 25, 1952, and she stated that her last menstrual period began on Dec. 19, 1951. Examination revealed no abnormalities except for the pelvis. The uterus was enlarged to just below the umbilicus, and bimanual vaginal examination revealed the presence of the same mass in the pelvis, as was found five years previously. It was apparent that the interpretation of the free cystic ovary that was found at cæsarian section was erroneous. Since it was believed that at this stage of pregnancy, the placenta had taken over the function of corpus luteum of pregnancy, it was recommended that pelvic laparotomy be performed, and if the pelvic obstruction could be removed, vaginal delivery would be possible. On this occasion the patient was not too concerned with the possibility that surgery might precipitate a miscarriage, and she consented to submit to surgery.

On May 7, 1952, a laparotomy was performed, and when the pregnant uterus was displaced anteriorly, a large cyst of the left ovary was found to occupy the entire true pelvis. It was bound to the pelvic walls by numerous broad but fairly thin adhesions. The mass was delivered out of the pelvis with only slight difficulty, and it was removed along with the fallopian tube. When the mass was opened it was found to contain vast quantities of sebaceous material and hair. The hard portion felt on vaginal examination proved to be a hard palate from which protruded one small tooth. The postoperative course was uneventful, as was the ensuing prenatal period. She volunteered the information that she felt better than she had in the past six years, in that she was not plagued with severe constipation. Since the mass had compressed the rectum, the reason for her sense of well being becomes obvious.

At 1:30 a. m. on Sept. 28, 1952, the patient delivered spontaneously a 6½ pound boy in OLA position after eight hours of labor. A median episiotomy was performed.

First National Bank Building

DELIVERY OF THORACOPAGUS TWINS

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Detroit Physiological Society

MEETINGS OF OCTOBER 16, 1952, AND NOVEMBER 20, 1952

The Growth and Cytopathogenic Effects of Viruses in Tissue Culture Fibroblasts

C. S. Stulberg, Ruth Schapira, and
C. Richard Eidam
The Child Research Center of Michigan

The growth patterns and cytological effects of strains of influenza A virus and herpes simplex virus were studied in cultures of fibroblasts derived from different tissues of the chick embryo. Group B Coxsackie virus was studied in fibroblasts developed from tissues of infant mice. Influenza virus failed to multiply in fibroblasts isolated from the lung, heart, skeletal muscle or cornea tissue of chick embryos, but did multiply in lung and cornea tissues when cells carried over from the embryo tissues were present. Cytopathogenic effects of the virus were not observed. Herpes simplex virus grew well in fibroblasts isolated from lung, skeletal muscle, and heart tissues of the chick embryo. With the propagation of herpes simplex virus, destruction of cells occurred until few normal cells remained and virus production ceased. The results with cultured tissues conform closely with the capacities of these viruses to multiply in specific cells and tissues of the chick embryo itself. Group B Coxsackie virus multiplied in fibroblasts isolated from the interscapular fat pads of infant mice, paralleled by a progressive cytopathogenic effect which continued until nearly all fibroblasts were destroyed.

The Initiation of Blood Coagulation in Hemophilia

Shirley A. Johnson and Charles L. Schneider
Wayne University Medical School

In the clotting of blood, prothrombin may be converted to the active enzyme thrombin through the action of thromboplastin and other accelerators. In extravascular clotting of shed blood, thromboplastin comes from the surrounding tissue, but the origin of a thromboplastin-like activity for clotting within vessels has not been elucidated.

Since it has been shown in this laboratory and elsewhere that platelets contain little or no thromboplastin it was important to determine what they do contribute. Platelet extract with a plasma globulin was found by Milstone to activate purified prothrombin in the presence of calcium ions. This observation has been confirmed and extended. It has been found that both platelet extract and the plasma globulin (platelet co-factor) must be present together to produce prothrombin activation. The platelet extract and plasma globulin can again be separated and neither one, by itself, can then activate purified prothrombin.

Early investigators suggested that hemophilia was essentially not a deficiency of the blood platelets but instead a condition concerned with a lack of a plasma component. This could be the platelet co-factor mentioned above.

In our assay, diluted hemophilic plasma would *not* activate purified prothrombin as rapidly as an equal amount of similarly treated normal plasma. The *amount* of thrombin produced by hemophilic and normal plasma was the same. However, the rate of prothrombin conversion to thrombin was slower when hemophilic plasma was tested. The rate of prothrombin conversion could be increased when hemophilic plasma was mixed with a partially purified preparation of the platelet co-factor from plasma. A transfusion of normal plasma also enabled the hemophilic plasma to activate purified prothrombin more rapidly.

Sterilization of Arterial Homografts

Ralph E. Carlson, Peter C. Trafas, and
Conrad R. Lam
Henry Ford Hospital

It would be desirable if blood vessel material obtained at routine autopsies (and consequently unsterile) could be sterilized to kill bacteria and viruses without denaturing the tissue so that it would not function as a homograft. The agent diacetylethylene (DAE), which has been tried as a virucidal material in plasma, was investigated

first. Sections of the aortas of donor animals were contaminated with virulent cultures and stored for varying periods after decontamination with DAE. Storage was carried out in an ordinary refrigerator with the grafts suspended in modified Tyrode's solution. When the grafts were implanted in the abdominal aortas of recipient animals within five days of decontamination, all of the animals died of hemorrhage from breakdown of the suture lines. In segments implanted later, there was a high incidence of thrombosis and degenerative changes in the grafts.

In a second series, the agent betapropiolactone was used to decontaminate the grafts. Preliminary results indicate that this substance is a reliable antibacterial agent and preliminary results indicate that no adverse effects have been produced on the graft material.

Reactions and Modifications of Some Blood Proteins Connected with Coagulation

L. Lorand
University of Leeds, England, and Wayne University

Recent studies on blood proteins threw light on some of the clotting reactions.

Fibrin-Stabilizing-Factor.—The physiologically formed plasma clot is insoluble in 30 per cent (w/v) urea in which fibrin obtained by the action of purified thrombin on purified fibrinogen easily dissolves. This reveals that the internal network structure of the two clots is different. In fibrin the particles are linked together by secondary forces, but in plasma clot, they are bound more strongly. The sequence of clot formation: fibrinogen, urea-soluble fibrin, urea-insoluble plasma clot resembles the keratinization of the skin protein, epidermin, as described by Rudall. In addition to Ca-ions, a thermolabile component of the serum: fibrin-stabilizing factor is essential in the production of a urea-insoluble plasma clot. In collaboration with Dr. Kekwick we purified the fibrin-stabilizing factor and it was found that the factor separates with globulin P-fraction in the low temperature-ether fractionating scheme.

Fibrino-peptide.—The comparison of the N-terminal residues of fibrinogen and fibrin, and the study of nitrogen partition during clotting showed that an acidic peptide, called fibrino-peptide, is split off from fibrinogen by thrombin. The transition of fibrinogen to fibrin follows the example of the pepsinogen-pepsin or ovalbumin-plakalbumin transformation inasmuch as in all three cases the primary protein is converted into a new protein species by loss of a peptide. This kind of reaction may be a common pattern in the biogenesis of a number of proteins. Fibrino-peptide has been isolated in an apparently pure form and its molecular constitution has been studied.

Mechanical Heart Blood Pressure Patterns Which Permit Direct Visualization of the Mitral Valve in the Living Animals

Robert A. Gerisch, M.D.; F. Dewey Dodrill, M.D.; Edward Hill, M.D., and Aran S. Johnson, M.D.
Harper Hospital

The normal arterial pressure pattern is due chiefly to ventricular ejection. Were it not for the energy imparted by ventricles to the fluid vascular compartment, the blood pressure in the arteries would soon be dissipated. Therefore, by analyzing blood pressure patterns we learn more about the amount of work which the ventricles in the living animal are doing. Even though blood pressure is affected by other factors, such as blood viscosity, peripheral resistance, blood vessel distensibility, et cetera, the primary source of energy is derived from the ventricles. Just as the arteries have pressure patterns characteristic of arteries, so do the ventricles exhibit their own characteristic pressure pattern.

With the same technique we use to record "heart pressure" patterns in animals, other pumps can also be tested for their characteristic pressure patterns.

Our studies have been concerned with the temporary substitution of a mechanical pump to do the work of (1) the "right" heart, (2) the "left" heart and (3) both right and left sides of the heart, so that the part of the heart which is bypassed can be opened for direct vision surgery.

By recording simultaneously the mechanical heart pump pressure pattern, the aortic pressure

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President's Message

"So Much for So Little"

There are many things scientific or socio-economic in nature that one could comment about in this state of flux in which Medicine now finds itself. But this one time I seem constrained, due in part to our immediate Past-President Beck's immense interest and effort in the Beaumont Memorial, aided by the constant work of Drs. A. H. Whittaker and W. J. Jones, to urge every member of our Society to do his share in preserving this monument to Medicine.

A large share of the cost of this project has been donated and its completion is now assured, but allow me to predict there will not be one member who will not be proud to say he has shared in this gift to the public commemorating one of the important events of all medical history. Talk to your non-medical friends and observe their enthusiasm for such a public-spirited enterprise undertaken by Medicine. Think for a moment how many dollars you have spent foolishly during the last year; yet this is a "buy" in which you cannot be disappointed. The average donation is approximately eleven dollars. I believe there is not a member of our group who couldn't afford a gift of one dollar upward to enable him to indulge in the pride of doing something in the public interest redounding to his own credit. I am sure you will never be able to get "so much for so little."

R. J. Hubbell

President, Michigan
State Medical Society

Editorial

THE BEAUMONT MEMORIAL

THE MICHIGAN State Medical Society is happy to devote this number of THE JOURNAL to the Beaumont Memorial project. That shrine and its proper preservation has been a major objective for many years, and now is within reach. President Otto Beck has devoted a great part of his time and energy, during his term in office and since, to conclude this endeavor. The land was purchased some time ago through the generosity of Parke, Davis & Co. Extensive research has been conducted by Prof. Emil Lorch, and designs made for an exact reproduction of the original Fur Company Store.

Hopefully, this shrine will represent the Medical Doctors of Michigan. A great number have joined in the enterprise, and sufficient money is on hand to warrant starting construction. Additional funds are needed, however, and it is hoped a greater number of our members will join. This memorial is promised perpetual care and maintenance, so it will be an enduring proof of medical progress.

If you have not yet sent your check, please do so now. Don't wait and forget.

HEALTH CARE OF THE NATION

THERE HAS BEEN agitation among many groups of people for two decades or more looking toward supplying medical and hospital care to *all* the people of the nation. Demands were made which spelled socialized medicine. Government claimed that the responsibility for complete distribution of health services must be assumed by the medical profession, else government would step in and furnish the services itself. Numerous bills were introduced in the Federal Congress, to which the profession objected.

The Doctors of Medicine in Michigan, becoming tired of always opposing legislation or fighting aggression all the time, decided to do something tangible. We evolved our Michigan Medical Service and its kindred organization, Michigan Hospital Service. These are voluntary non-profit prepayment health service groups. Anyone (at first only in groups), who wishes, may provide for his medical and hospital services by voluntary prepayment. He may spend his money on other things, but if he chooses to buy health care, it is available on a voluntary basis, with free choice of physician or hospital. At first, Michigan Medical Service gave full coverage—home, office, hospital, but the cost due to adverse utilization was prohibitive, and finally medical service in hospital only was adopted.

This was an outstanding Michigan accomplishment.

During one of the hearings recently conducted by the President's Commission on the Health Needs of the Nation, a proposal made by speakers from Michigan, which was released to the press on October 30, 1952, was seized upon by the Federal Security Administrator and publicized widely. This plan is the American Federation of Medical Centers, Inc., and claims to be a new type of national medical care program under private operation. Briefly "the plan provides complete hospital, medical, surgical and dental care to individuals at a cost of one to two dollars a week, varying by communities. Communities will be shown how to establish medical centers, giving them all the advantages of great national medical centers, right in their own home town."

"The American Federation of Medical Centers, Inc., has formulated a program which includes the following primary recommendations: (1) The banding together of community leaders to provide new medical centers which will permit physicians and other professional personnel to work at maximum efficiency. (2) The establishing of community centers to make available to the public, under one roof, a group practice program of preventive as well as curative medicine, conducted by a balanced team of general practitioners, specialists, dentists, nurses and other technicians. (3) The offering to the community of a program of modern medical care, financed by a system of voluntary prepayment available to all sections of the population.

"We believe we have the fully documented answer to the demand for an overall plan by which in a reasonable time, and at a reasonable cost, everyone can have the medical care he requires, and for which he can pay. . . . Under group insurance coverage, the cost for complete health protection, according to the American Federation Medical Centers plan, is not expected to exceed the amount now paid by the average person, or paid by others in his behalf."

The federation is a non-profit organization, founded by Edgar H. Norris, M.D., former Dean of Wayne University Medical School. This is another plan developed in Michigan, but sounds to us quite similar to several plans already in operation—The Permanente organization and the Ross-Loos Clinic, in California. The fundamental objection to both is that their plan is group practice, simply, operating with all the staff on salaries. We recognize the fact that other famous clinics have salaried arrangements, but they do not give health care on the insurance basis.

The third plan for the health care of the nation has just been reported by The President's Commission on the Health Needs of the Nation. This report is not yet available for study, and specific comments will be withheld. Sufficient now is the mention of point 4 which reads, "Funds collected through the OASI (Old Age and Survivors Insurance) mechanism may be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance group, under a plan which meets Federal standards, and which does not involve a means test."

While not saying so, this means *compulsory national health insurance,* which the medical profession, the people and the Congress have repeatedly turned down. There is also a suggestion that the existing voluntary, non-profit health plans be subsidized to an extent which might reach a billion dollars to make the services available to beneficiaries of federal and local aid.

This question of subsidy has been shunned by the voluntary plans since their inception, because of fear of losing their independence. This fear was justified by the Federal Supreme Court when it ruled that anything the Federal Government subsidizes, it shall control.

We await the Magnuson Commission's report, and promise adequate and considered study, but we must at present withhold support. This report and its usages will concern the next Administration, not Harry S. Truman who has always favored the socialized approach.

Under private enterprise, individual and group accomplishments, a very satisfactory health care program has been created and has been subscribed to by much over half of the population of the nation, and this entirely without governmental or bureaucratic help. It has been demonstrated that success may be obtained in spite of bureaucratic opposition, and a worthwhile health care be given to all who wish it. The evidence of success of this program is the constantly increasing improvement of health and mortality records during the life of these plans.

DETROIT PHYSIOLOGICAL SOCIETY

Mechanical Heart Blood Pressure Patterns

(Continued from Page 204)

pattern, and the electrocardiogram, one can see when the aortic pressure pattern is completely replaced by the "mechanical heart" pressure pattern. When only the "mechanical heart" pressure pattern is seen in the aorta, then no blood is being ejected from the ventricle, and the heart can be opened for mitral valve examination without hemorrhage.

Laboratory Evaluation of Antiepileptic Agents

GRAHAM CHEN and CHARLES R. ENSOR
Parke, Davis and Company

A number of antiepileptic drugs (the derivatives of barbituric acid, hydantoin, succinimide, oxazolidone, and amides) were chosen for study of their anticonvulsant activities in laboratory animals. A fair agreement was found between their suppressive effect in Metrazol and electrically induced convulsions and their efficacy in the management of petit mal and grand mal epilepsy.

Phenobarbital and pentobarbital (or barbital) were shown to differ in their anticonvulsant properties in that only the former possesses at non-hypnotic levels an antielectroshock action similar to that of Dilantin.

The relationship between chemical constitution and anticonvulsant activity was investigated with the hydantoin, succinimide, and the oxazolidone derivatives. The presence of the lower alkyl members at the carbon atom in the ring increases the anti-Metrazol potency of these compounds, but exerts only a very slight influence on their antielectroshock activity. The reverse is the case with the phenyl radicals. An increase in both anti-Metrazol and antielectroshock activities is achieved by the introduction of an alkyl and a phenyl group at the same carbon atom.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

PHYSICIAN URGENTLY NEEDED ON BEAVER ISLAND

What is undoubtedly one of the unique medical practices in the country—the position of physician on Michigan's historic little Beaver Island—is vacant and is urgently in need of an interested applicant. Since the retirement of Dr. R. E. Palmer in September, the Island's 500 year-around residents have been without medical service. The coming of winter has made their situation serious.

Beaver Island is a part of Charlevoix County, lying in northern Lake Michigan, 35 miles from the mainland. It has a year-around population of 500 persons, with a summer influx of an additional 1,500 to 2,000. Boat service is frequent during the open-water season but from December through April communication is only by telephone, plane or sled.

Since 1923, when the Island residents appealed to Governor Groesbeck for help in keeping a physician in year-around residence, the Legislature has made a regular appropriation for a "Beaver Island Physician." As a matter of bookkeeping procedure, the item has been attached to the Michigan Department of Health budget, carried as a separate account.

The position is under State Civil Service and the state employes' retirement system. The salary range is $5808 to $6576, plus all fees collected. The previous incumbent had a contract to care for local Coast Guard personnel that amounted to $300 a year. A Michigan license is required.

The Beaver Island opening offers a challenge to service reminiscent of frontier days. Dr. A. E. Heustis will welcome inquiries from any physician interested and will be glad to furnish additional information.

INTOXIMETER TEST RESULTS ADMITTED AS EVIDENCE

In a recent court case in southeastern Michigan involving a man charged with driving under the influence of intoxicating liquor, the results of an Intoximeter test were admitted as evidence by the judge, over objection.

The Intoximeter is a readily portable device about 3 inches in diameter and 10 inches long which measures alcohol circulating in the blood, by means of an analysis of the breath. The admissibility of results of the test as evidence in court cases has been a matter of legal controversy.

MORE ABOUT SALMONELLA MONTEVIDEO

As a sequel to the recent shipment into the state of a powdered egg yolk product found to be contaminated with Salmonella Montevideo, identification of the organism has been made in four cases of Salmonella infection in children. In each of the four cases, the egg yolk product had been used.

COMMISSIONER'S YEARLY SUMMARY HIGHLIGHTS ACCOMPLISHMENTS

"Summing Up for 1952" is the title of the expanded December issue of the Department's monthly bulletin, *Michigan's Health*, outlining major activities for the year.

The Division of Laboratories performed approximately 1,307,200 diagnostic tests through the Lansing, Grand Rapids, Houghton and Powers laboratories, highest work load total in their history.

An estimated 3,657,500 doses of serums and vaccines were distributed to physicians and health officers, also a record total. These were produced in the laboratories at Lansing.

Continued investigation work on the bacteriology of infant diarrhea has shown that E. coli 111, B_4 and 55 are undoubtedly two of the infectious agents responsible for diarrhea of the newborn. Feeding experiments with adult human volunteers have shown that E. coli 111, B_4 and 55 are capable of causing gastro-enteritis when administered in sufficient quantities.

The Laboratories' Blood Plasma Program continued at an accelerated pace in the collection and fractionation of blood. The program is providing blood plasma, albumin, immune serum globulin, antihemophilic globulin and resuspended cells to sixty-five counties in Michigan.

Department mobile X-ray units screened approximately 205,630 persons for tuberculosis in community case-finding surveys.

Over 130,000 school children were screened for hearing loss in co-operative programs during the school year. Seventy practicing otologists have co-operated in medical examinations of children discovered to have hearing loss.

Industrial Health Division engineers made 3,927 visits to plants employing 498,885 workers. Nearly 90 per cent of recommendations were carried out.

Approximately 300,000 vital records were processed during the year, bringing the total on file in the Department's vaults close to 13,000,000.

To local health departments and individuals, the Department supplied nearly 1,000,000 pamphlets and 600,000 persons saw motion picture films from the Department's loan library.

HEALTH OFFICERS APPOINTED

Alfred L. Wood, M.D., has been appointed director of the Dearborn City Health Department.

Gerald W. Behan, M.D., has been appointed director of the Grand Traverse-Leelanau District Health Department.

There is no substitute for cystoscopic examination and biopsy in the diagnosis of vesical neoplasms.

* * *

A cystoscopically invisible but symptomatic vesical neoplasm is a rarity.

* * *

Despite the great mass of research done on therapy of leukemia in recent years and the plethora of new treatments introduced, the fact remains that it is still impossible to cure leukemia or even to alter drastically the course of the disease.

* * *

Acute leukemia in adults is refractory to chemotherapy.

* * *

The principal toxic manifestation of the antifolic compounds is gastrointestinal disturbances with ulceration, bleeding and diarrhea.

* * *

For chronic leukemia, irradiation remains the treatment of choice, no chemotherapeutic agent having been proved to have better effects.

Dramamine® in Vertigo

The remarkable relief afforded by Dramamine in motion sickness has led to studies of its possible value in allied conditions.

Dramamine apparently depresses hyperstimulation of the vestibular apparatus. Thus it is an effective means of relieving the nausea and vertigo which characterize dysfunctions of the middle ear.

Accepted Uses for Dramamine

(BRAND OF DIMENHYDRINATE)

MOTION SICKNESS

NAUSEA and VOMITING associated with

- pregnancy
- drugs (certain antibiotics, etc.)
- electroshock therapy
- narcotization

VESTIBULAR DYSFUNCTION associated with

- streptomycin therapy

VERTIGO in

- Ménière's syndrome
- hypertensive disease
- fenestration procedures
- labyrinthitis
- radiation sickness

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE *Research in the Service of Medicine*

In Memoriam

HAROLD DE BLOIS BARSS, M.D., of Ypsilanti, died December 7, 1952, at the age of sixty-six.

During the past thirty-three years, he had served the community of Ypsilanti as a surgeon. Dr. Barss was graduated from the University of Michigan Medical School in 1914. Following his graduation, he served on the surgical staff of University Hospital, Ann Arbor, from 1914 until 1918.

Dr. Barss had served on the Ypsilanti Board of Education from 1933 until 1938. He was a member of the Washtenaw County Medical Society and a Fellow of the American College of Surgeons.

He was a staff surgeon at St. Joseph Mercy Hospital, Ann Arbor. During World War II, Dr. Barss was a member of the Civil Air Patrol.

Dr. Barss is survived by his wife, a daughter, Mrs. Barbara L. Graham, and a son, William A. Barss, M.D., of Ypsilanti. He also leaves his mother, Mrs. W. E. Witter, of Rochester, N. Y., and two brothers, Howard P. Barss, of Portland, Oregon, and Alden F. Barss, of Vancouver, B. C.

PETER BUHRMAN, M.D., of Ann Arbor, died November 29, 1952, at the age of twenty-eight.

Dr. Buhrman was graduated from the Wayne University College of Medicine in 1949 and interned at St. Joseph's Mercy Hospital, Ann Arbor. He had just finished two years of service in the Air Force Medical Corps and was to return to St. Joseph's at Ann Arbor December 1, 1952, to finish his residency training.

He was an associate member of the Michigan State Medical Society.

MARIA BELLE COOLIDGE, M.D., of Detroit, died December 26, 1952, at the age of seventy-eight.

Dr. Coolidge, who had practiced medicine in Detroit for the past forty-five years, was the first woman surgeon in the Army Medical Reserve Corps. During World War I, she was the first doctor of medicine of her sex to attain the rank of first lieutenant in the medical corps. She served in France during World War I.

Dr. Coolidge was graduated from the Cincinnati Medical College in 1907. She was a member of the Wayne County Medical Society and a life member of the Michigan State Medical Society.

Dr. Coolidge is survived by a brother, The Rev. John K. Coolidge, of Euclid, Ohio; and a sister, Mrs. Frank W. Coolidge, of Detroit.

HUGO A. FREUND, M.D., of Detroit, died December 24, 1952, at the age of seventy-one.

For the past forty-five years, he had served Detroit as a doctor of medicine with a primary interest in internal medicine. Dr. Freund was also a civic leader in Detroit for many decades. He was graduated from the University of Michigan Medical School in 1905. He remained at the University Hospital for two years following his graduation as an assistant instructor of internal medicine. He came to Detroit in 1907 to begin his practice. He took postgraduate studies in Germany in 1911 and 1912.

He became a member of the Harper Hospital staff in 1909, and in 1927 was named Chief of Internal Medicine at Harper Hospital, a post he held until 1945. At the time of his death, he was senior consultant of internal medicine at Harper Hospital and consultant at Receiving and Children's Hospitals and at Haven Sanitarium. He was also a member of the Board of Trustees of the proposed Oakland County Hospital. Dr. Freund was to

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HUGO A. FREUND

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have been Director of Research at the new Mt. Sinai Hospital which opened in Detroit a few days after his death.

Long noted as a civic leader, Dr. Freund was a member of the City Welfare Commission from 1936 to 1940 and was a member of the Detroit Board of Health from 1917 to 1930. Dr. Freund became a trustee of the Children's Fund of Michigan, an activity sponsored by the late Senator James Couzens, and served from 1929 until his death. He was re-elected president of the Fund year after year. Since 1951, he had been president of the Child Research Center.

Besides being a member of the Wayne County Medical Society, he was a Life Member of the Michigan State Medical Society, a Diplomate of the American Board of Internal Medicine, a member of the American Association of Pathologists and Bacteriologists, the Central Society for Clinical Research, a Fellow of the American College of Physicians, and a past president and director of the Michigan Chapter of the Arthritis and Rheumatism Association.

During World War I, he served as a captain in the Medical Officers Reserve Corps.

Dr. Freund is survived by his wife, Ruth; two daughters, Mrs. Barnett Malbin, of Detroit, nad Mrs. Edgar Alexander, of Evansville, Indiana. He also leaves a son, Richard A. Freund, of Birmingham, and six grandchildren.

JAMES L. HENDERSON, M.D., of Detroit, died December 5, 1952, at the age of sixty-six.

Dr. Henderson was graduated from the Detroit College of Medicine in 1914 and interned at Parkside Hospital, Detroit. He was an obstetrician.

Dr. Henderson was on the staff of Parkside and St. Francis Hospitals, Detroit. He also taught pediatrics and obstetrics at the Nurses Training School, Dunbar Memorial Hospital, Detroit. He was medical director of Mercy Hall Hospital.

Dr. Henderson was a member of the Wayne County Medical Society and a Hamtramck Councilman from 1922 to 1924.

He is survived by his wife, Edna, and three children. They are Langston, James, and Mrs. Ruth Bouier. He also leaves two brothers and two sisters.

FRANK J. HODOSKI-HODGES, M.D., of Detroit, died December 13, 1952, at the age of fifty-two.

He had practiced in Detroit for the past twenty-four years and was primarily interested in internal medicine. Dr. Hodges was graduated from Ohio State University College of Medicine in 1928 and interned at Receiving Hospital, Detroit, in 1929.

He was on the staff of Grace and Chenik Hospitals, Detroit.

Dr. Hodges is survived by his wife, Allie; three children, Donald, Janet, and Carol; three brothers and three sisters.

WILLIAM Y. KENNEDY, M.D., of Detroit, died December 28, 1952, at the age of sixty-two.

Dr. Kennedy was graduated from the Detroit College of Medicine in 1913 and joined his late father, J. B. Kennedy, M.D., in the practice of medicine. Dr. Kennedy had been on the staff of Grace Hospital for nearly forty years.

Dr. Kennedy was an industrial surgeon and for many years had been surgeon for the D&C Navigation Company.

He was a member of the Wayne County Medical Society and the American Association of Industrial Physicians and Surgeons.

Dr. Kennedy is survived by his wife, Gertrude, and three sons, William Y. Kennedy, Jr., Johnston B. Kennedy, and Pfc. Fred J. Kennedy. He also leaves two brothers, Charles S. Kennedy, M.D., and Fred J. Kennedy, both of Detroit.

EARL W. MAY, M.D., Detroit, died December 16, 1952, at the age of sixty-one.

He was graduated from the Detroit College of Medicine in 1916 and interned at Grace Hospital, Detroit.

Dr. May retired from active practice in 1945 due to illness but prior to that had served as Chief of Pediatrics at Grace Hospital for fifteen years and was Consulting Pediatrician at Herman Kiefer Hospital, Detroit. He was also an instructor in pediatrics at Wayne University College of Medicine. For several years he served as Director of Child Welfare of the Detroit Health Department.

During World War I, he served as a transport surgeon.

Dr. May is survived by his wife, Evelyn; a daughter, Mrs. Carol M. Hollingshead; a son, Donald G. May, M.D., of Kalamazoo, and a sister, Helen E. May.

ALFRED E. VAN NEST, M.D., of Detroit, died December 9, 1952, at the age of fifty-seven.

He was graduated from St. Louis School of Medicine in 1918. Dr. Van Nest served his internship at Providence and St. Luke's Hospitals in St. Louis, Missouri. Before coming to Detroit in 1920, Dr. Van Nest, a surgeon, did postgraduate work at the Chicago College of Surgery.

He was a member of the staff of Detroit Memorial and St. John's Hospitals.

Dr. Van Nest is survived by his wife, Helen, and four daughters. They are Mrs. John Parshem, Mrs. John Varty, Mrs. John Marley and Mrs. George Seeger, of Detroit. He also leaves a brother, Edward, of Jackson.

ROBERT J. PALMER, M.D., of Detroit, died December 2, 1952, at the age of seventy-seven.

Dr. Palmer, formerly the chief surgeon at Grace Hospital, Detroit, studied medicine at the University of Toronto and in London, England, and Edinburgh, Scotland. He received his medical degree in 1899.

He was a member of the executive committee of Grace Hospital for twenty-five years. An Emeritus Member of the Michigan State Medical Society since 1950, he was also a member of the Wayne County Medical Society and a Fellow of the American College of Surgeons.

Dr. Palmer is survived by his wife, Emma; a daughter, Mrs. Edward S. Lambrecht, of Grosse Pointe; a sister, Mrs. F. H. Hayhurst of Toronto, and four grandchildren.

W. CLARE SKINNER, M.D., of Detroit, died November 23, 1952, at the age of sixty.

Dr. Skinner, who was graduated from the University of Michigan Medical School in 1919, served his internship at Harper Hospital, Detroit. He was on the staff of Mt. Carmel Mercy Hospital, Detroit.

He was interested in industrial medicine and was a member of the American Academy of General Practice, and the Wayne County Medical Society.

Dr. Skinner is survived by his wife, Ruth; a daughter, Mrs. DeRhua Swears, of Tokyo, Japan, and six grandsons.

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

R. M. Nesbit, M.D., and **W. C. Baum, M.D.,** of Ann Arbor, Michigan, are the authors of an article, "Antibiotic and Chemotherapeutic Agents in Infections of the Genitourinary Tract," published in *The Journal of the American Medical Association,* December 13, 1952.

H. M. Pollard, M.D.; R. J. Bolt, M.D.; H. K. Ransom, M.D., and **J. E. Orebaugh, M.D.,** of Ann Arbor, are the authors of an article, "Comparison of Results of Vagotomy and Subtotal Gastrectomy for Duodenal Ulcer," published in *The Journal of the American Medical Association,* December 13, 1952.

C. C. Sturgis, M.D., of Ann Arbor, is the author of an article, "Some Aspects of the Leukemia Problem," published in *The Journal of the American Medical Association,* December 20, 1952.

E. H. Steffensen, M.D., of Detroit, is the author of an article, "Corticotropin, Cortisone, and Hydrocortisone in Treatment of Ocular Disease," published in *The Journal of the American Medical Association,* December 27, 1952.

Von Hermann Pinkus, M.D., of Monroe, is the author of an article, "Bullous Variety of Incontinentia Pigmenti (Bloch-Sulzberger)," published in the *Archives of Dermatology and Syphilology,* May, 1952.

Von Hermann Pinkus, M.D., of Monroe is the author of an article, "Granuloma faciale," published in *Dermatologica* (International Journal of Dermatology, Basel, Switz.) Vol. 105, No. 2, 1952.

* * *

"To a Better Living."—The editorial from THE JOURNAL for October bearing the above caption was quoted on the Editorial Page of the *Journal of the West Virginia Medical Society* for December, 1952.

* * *

Correction: In the November THE JOURNAL, in the editorial reporting the elections, four words "of Michigan Medical Service" were inadvertently omitted in the third paragraph, second column, on page 1464, at the end of the second line. The sentence should read "During the session of the Michigan State Medical Society elections to the Board of Directors **of Michigan Medical Service** were held." The list of officers which follows are those of Michigan Medical Service, not Michigan State Medical Society.

* * *

Gifts to the American Medical Education Foundation are deductible in income tax reports. They are given official recognition in *The Journal of the American Medical Association* and in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY. The MSMS Council urges full support of this very constructive program, one that will prove that aid to medical education need not come from Federal sources and that our medical schools can remain free of Governmental domination (socialized education).

* * *

"The Story of Cancer for High Schools," a brochure prepared by the MSMS Cancer Control Committee and published through the help of the Michigan Department of Health, is being distributed to all public and parochial high schools of Michigan. Copies have been sent to the Secretary of every component county society in this State. Whenever called upon for talks or other cancer education assistance by the high schools, your members now have a worthy publication to use; they are urged to participate in this important educational activity. (This marks another important "FIRST" for Michigan).

* * *

Medical Civil Defense Information.—The county medical society is the logical unit for dissemination of this important information to the M.D.'s of the State. The MSMS Emergency Medical Service Committee requests county medical societies to set aside proper time necessary to make their membership aware of plans and basic principles of the medical aspects of civil defense. For a speaker to appear before your county society on this subject, write William Henry Gordon, M.D., Chairman, Emergency Medical Service Committee, c/o Box 539, Lansing 3. *(Atomic Energy-Civil Defense* will be featured in a talk by Paul Aebersold, Ph.D., of Oak Ridge, Tennessee, on Wednesday, March 11, at 8:30 p.m., Grand Ballroom, Sheraton-Cadillac Hotel, Detroit —during the 1953 Michigan Clinical Institute.)

* * *

Health Group Award Winners.—Winners of the annual awards sponsored by the Michigan Health Council were announced by Dr. J. S. De Tar, council president.

The Dearborn Health Council was named to receive the Andrew S. Brunk award for the outstanding community health council program for 1952. The council was cited for an aggressive job done in promoting a series of community health projects.

An award for the outstanding news story on community health activity went to Gretchen Reinhardt of the *South Macomb News,* East Detroit, for her story on the Center Line Health Council's Well Baby Clinic.

The Hale Health Council of Iosco County was named

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the award winner among community health councils whose programs are less than a year old.

A special award for public health workers performing service beyond the line of duty went to Ruth Tappan, a registered nurse with the Calhoun County Health Department.

The awards were presented at the banquet program of the sixth annual Michigan Rural Health Conference at Michigan State College, January 16 and 17, 1953.

* * *

March of Dimes Nurse Recruitment.—A March of Dimes grant of $35,837 will assist the Committee on Careers in Nursing to continue its program of recruitment of students for nursing education. This was announced jointly by Basil O'Connor, President of the National Foundation for Infantile Paralysis, and Theresa I. Lynch, Chairman of the Committee on Careers in Nursing, National League for Nursing.

Since 1949, the National Foundation has provided financial assistance to the Committee on Careers in Nursing, which is supported by national nursing, medical and hospital organizations along with other professional and business groups, and has carried on an intensive recruitment program. For the third year the grant will underwrite the Committee's field services program to intensify the recruitment of students for both professional and practical nursing schools.

In commenting on the March of Dimes grant, Miss Lynch said, "The present inadequate supply of nurses is a crucial problem to the National Foundation for Infantile Paralysis and to every individual or agency concerned with the care of the sick. The demand for nurses continues to exceed the available supply. At present, the estimated shortage of nurses for civilian needs alone is 50,000."

Since adequate nursing is an important element in the treatment of polio patients, the National Foundation for Infantile Paralysis is actively supporting the recruitment of nurses.

* * *

Parent Institute on Nursery School for the Hard of Hearing.—The thirtieth annual parent institute on nursery school sponsored by the Michigan School for the Deaf will be held March 22 through 27, 1953, on the Campus of the Michigan School for the Deaf. Dr. Willard Olson, dean of the School of Education and director of research in child development at the University of Michigan will be the banquet speaker. He will speak on "Child Development."

The program for the parents, consisting of classes, observations, consultations, scheduled tours and lectures, has been planned to assist parents with their child during the preschool years. There is much parents can do to train their child during these early years and help him to develop habits and patterns which will be important to him throughout his life.

The program for the children is one of attendance at a nursery school to help start them on the road to new experiences in learning.

Attendance is open to any mother or father (or both)

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of this State and their deaf or hard-of-hearing preschool child. Educators, rehabilitation workers, and other interested individuals are welcome to attend any or all meetings listed in the program.

There will be no charge to parents and children attending the institute.

* * *

National Health Conference in 1953.—New developments in methods for protecting and improving the health of the American worker and of insuring his safety will be reported by the nation's leading industrial doctors, dentists, nurses and hygienists at the 1953 National Industrial Health Conference to be held in Los Angeles, April 19-24.

Professional groups participating in the conference will be the American Conference of Government Industrial Hygienists, United States Navy Industrial Health Organization, American Association of Industrial Dentists, American Industrial Hygiene Association, Industrial Medical Association, and the American Association of Industrial Nurses.

This is the first time the six groups have ever scheduled their sessions together on the West Coast. Phenomenal increase in industrial activity in this area, particularly in Southern California, has finally attracted this important national conclave.

George F. Wilkins, M.D., medical director of New England Telephone and Telegraph Company, is president-elect of the Industrial Medical Association.

Michigan doctors attending the December AMA Session were: Warren W. Babcock, M.D., Detroit; Donald R. Ballard, M.D., Dearborn; R. E. L. Berry, M.D., Ann Arbor; B. B. Blum, M.D., Petoskey; Paul R. Boothby, M.D., Lawrence; William Bromme, M.D., Detroit; R. H. Denham, M.D., Grand Rapids; J. S. DeTar, M.D., Milan; L. J. Gariepy, M.D., Detroit; Harold H. Gay, M.D., Midland; J. P. Gray, M.D., Detroit; and Harry Greenbaum, M.D., Jackson.

M. R. Hannum, M.D., Milan; Wilfrid Haughey, M.D., Battle Creek; W. B. Howes, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo; Wm. A. Hudson, M.D., Detroit; W. H. Huron, M.D., Iron Mountain; W. A. Hyland, M.D., Grand Rapids; R. A. Johnson, M.D., Detroit; Jack Lapides, M.D., Ann Arbor; S. J. Nichamin, M.D., Detroit; R. L. Novy, M.D., Detroit; G. B. Ohmart, M.D., Detroit; C. I. Owen, M.D., Detroit; G. C. Penberthy, M.D., Detroit; Alfred J. Shreve, M.D., Dearborn; E. D. Spalding, M.D., Detroit; E. C. Texter, M.D., Detroit; and Lloyd A. Watts, M.D., Detroit.

* * *

Frederick F. Yonkman, M.D., formerly of Detroit and Wayne University College of Medicine, has been elected Vice Chairman in Charge of Research by the Board of Directors of Ciba Pharmaceutical Products, Inc., of Summit, New Jersey.

Dr. Yonkman was born in Holland, Michigan. He

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received his A.B. degree from Hope College in 1925, his Ph.D. degree from the University of Iowa in 1928, and his M.D. degree from Boston University School of Medicine in 1939. Dr. Yonkman is now on the teaching staff of the College of Physicians and Surgeons of Columbia University, and is also a director of the American Pharmaceutical Manufacturers Association.

Congratulations Vice President Yonkman!

* * *

Michigan Speakers at the AMA Clinical Session in Denver were: R. E. L. Berry, M.D., of Ann Arbor on "The Management of Acute Surgical Dehydration," and Jack Lapides, M.D., of Ann Arbor on "Fluid and Electrolyte Disturbances in Prostatism."

* * *

Frank H. Krusen, M.D., of Rochester, Minn., in an article "New Frontiers in Rehabilitation" in the December Number of "The Crippled Child" magazine, official publication of the National Society for Crippled Children and Adults, urges doctors of medicine to adopt the new concept of treating the patient as "a whole person" and to enlist aid of their communities in bringing about full recovery. He asks the physician to share responsibility for the ultimate restoration of the patient with community leaders, such as businessmen, scientists and educators. Copies of *The Crippled Child* magazine may be obtained by writing the editor, 11 S. LaSalle Street, Chicago 3, Illinois.

Two commendable innovations appear in the Bulletin of the Saginaw County Medical Society: (a) the monthly listing of the birthdays of members of Saginaw County Medical Society and (b) frequent insertions of a liner reading "Attend your medical society meeting."

* * *

The Michigan Academy of General Practice, at its meeting in East Lansing on November 17-18, elected the following officers: President: F. E. Luger, M.D., Saginaw; President-Elect: Karl L. Swift, M.D., Detroit; Secretary-Treasurer: Russell F. Fenton, M.D., Detroit. Board of Directors: Kenneth Johnson, M.D., Lansing, and John Rice, M.D., Kalamazoo (other members on the Board are: Charles G. Steinke, M.D., Iron Mountain; G. B. Saltonstall, M.D., Charlevoix; William F. Reus, M.D., Grand Rapids; W. B. Harm, M.D., Detroit.)

Delegates to the American Academy of General Practice: J. S. DeTar, M.D., Milan, and John H. Schlemer, M.D., Detroit. **Alternates:** Perry C. Gittins, M.D., Detroit, and Samuel J. Buist, M.D., Grand Rapids.

Lunette I. Powers, M.D., Muskegon, was presented with Honorary Membership in the Michigan Academy of General Practice.

The newly formed local Chapter of Ingham County was presented with its charter.

The idea of forming a House of Delegates was postponed to the 1953 Annual Meeting.

* * *

Qualifying examinations for Fellowship in the United States Chapter of the International College of Surgeons

will be held February 2-3, May 4-5, August 10-11, November 2-3, 1953. The examinations will be given at the Cook County Graduate School of Medicine, and the Cook County Hospital, Chicago. Applicants may address communications to Harry A. Oberhelman, M.D., Secretary, Qualification and Examination Council, 1516 Lake Shore Drive, Chicago 10, Illinois.

"Tuberculosis is a social disease and presents problems that transcend the conventional medical approach. . . . The impact of social and economic factors [must] be considered as much as the mechanisms by which tubercle bacilli cause damage to the human body."—From "The White Plague," a comprehensive story of tuberculosis by René and Jean Dubos. Dr. Dubos is a member of the Rockefeller Institute for Medical Research.

—Michigan Tuberculosis Association

In the 1953 Congress there isn't a Republican Senator who has served under a Republican President and only 15 House members have.—Chamber of Commerce of the United States, *Legislative Outlook*, January 5, 1953

The Cornell Medical Index Health Questionnaire was discussed in an article in the *Bulletin of the Genesee County Medical Society*, December 23, by Robert D. Scott, M.D., who reported on using the questionnaire with 140 patients in an eleven-month period.

* * *

L. J. Hirschman, M.D., Traverse City, addressed the Traverse City Rotary Club on January 20. His subject was "The Beaumont Memorial Restoration on Mackinac Island."

* * *

The American Society for the Study of Sterility announces the opening of the 1953 contest for the most outstanding contribution to the subject of infertility and sterility. For full particulars, write Herbert H. Thomas, M.D., 920 S. 19th Street, Birmingham, Ala.

* * *

Taxes: More money is paid for taxes than for food and clothing. Federal taxes cost $1,389 per family, and nearly $1,934 per family when the state and local taxes are included.

The public debt now represents $1,500 per person, and even the interest on the debt amounts to $140 per family! —George C. Smith, Manager, Government Economy Program, U. S. Chamber of Commerce, Washington, D. C.

Thomas M. Rivers, M.D., Rockefeller Hospital for Medical Research, New York, will be guest speaker at the special meeting of the Michigan Health Officers Association arranged coincident with the Michigan Clinical Institute.

Dr. Rivers will speak on "The Relation of Medical Research to Clinical Practice and Public Health" on Thursday, March 12, 1953 at 6:30 p.m. in the Pan American Room, Sheraton-Cadillac Hotel, Detroit.

The dinner meeting will be preceded by a reception honoring Dr. Rivers and the officers of the MHOA.

Medical practitioners and health officers of Michigan, Ontario, northern Ohio, northern Indiana and eastern Wisconsin, and their ladies, are cordially invited to attend this dinner meeting of Thursday, March 12, 1953, 6:30 p.m.

The lists of contributors to the Beaumont Memorial Restoration Fund appearing on pages 134-142 was incomplete at press time. To avoid delay in publication of the February issue, additional names will be listed in the March issue. If your name does not appear in the list this month, it will be listed next month.

According to a U. S. Chamber of Commerce report, every Federal Department with one exception—Justice—spent more money last July, August and September than in the same period of 1951. Total spending for the period, the first quarter of fiscal year 1952, was $17,800,000 or 19 per cent more than was spent in the same three months of last year. Spending of Federal Security Agency, including Public Health Service, was $663 million, as against $596 million, or an increase of 11 per cent. Veterans Administration was spending less. The Chamber notes that the sharpest increases were in "strictly civilian agencies." Departmental increases were: Agriculture 60 per cent, Commerce 6 per cent, Defense 26.4 per cent, Labor 60.2 per cent, Postoffice 16.7 per cent, State 53.8 per cent, and Treasury 3.4 per cent.—*Capitol Clinics,* Nov. 4, 1952.

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The Ingham County Medical Society met on December 16 and elected the following officers: President, K. H. Johnson, M.D., Lansing; President-Elect, H. E. Cope, M.D., Lansing; Secretary, J. L. Isbister, M.D., Lansing.

Delegates to MSMS: F. L. Troost, M.D., Holt; J. M. Wellman, M.D., Lansing; K. H. Johnson, M.D., and O. B. McGillicuddy, M.D., Lansing.

* * *

In 1951, 432,995 patients, 84.6 per cent of all patients discharged from Veterans Administration Hospitals in 1951, were veterans who were ill from non-service-connected disabilities. In other words, they were not ill

(Continued on Page 224)

(Continued from Page 222)

or disabled because of diseases or injuries suffered as a result of their military service but because of diseases and injuries incurred after they had returned to civilian life. The VA hospital and medical service is now costing taxpayers about $600,000,000 a year.

* * *

American football got its start in 1875 when McGill University played at Harvard. The first half was played under Rugby rules, the second under Soccer rules!

During later years the game was standardized as we know it today, with the forward pass being introduced in 1906.—*Northwestern Mutual Notes.*

* * *

Howard A. Rusk, M.D., New York (guest essayist on recent MSMS Annual Session and Michigan Clinical Institute programs), was awarded the Dr. C. C. Criss Gold Medal and $10,000 award in recognition of his work in rehabilitating the physically handicapped.

Congratulations, Dr. Rusk!

* * *

Surveys conducted in early December, 1952, by Smith, Kline & French Laboratories, Philadelphia, which cooperated with the American Medical Association in sponsoring telecasts from the AMA Interim Session in Denver, revealed overwhelming acceptance by the public of TV programs of this type.

The surveys also showed that the "March of Medicine" telecasts accomplished two objectives: (1) They informed the public of advances being made against major health problems, and (2) developed a better public understanding of the basic problems of medicine as reflected through the continuing research and postgraduate studies of doctors of medicine.

INGHAM COUNTY MEDICAL SOCIETY

Silver Anniversary—May Clinic

On Thursday, May 7, 1953, the Ingham County (Michigan) Medical Society will celebrate the Silver Anniversary of the formation of its Spring Clinic. This year's one-day meeting will be held, as in the past, at the Olds Hotel, Lansing, beginning at 2:00 p.m. The program follows:

Afternoon

EDITH POTTER, M.D. "Obstetrics"
University of Chicago
Medical School

WALTER PALMER, M.D. "Gastro-intestinal Disease"
University of Chicago
Medical School

G. G. DUNCAN, M.D. "Diabetes"
Jefferson Medical College

LOUIS A. BUIE, M.D. "Rectal Disease"
Rochester, Minn.

Evening

Social Hour—Dinner—Ballroom, Olds Hotel

R. B. ROBINS, M.D., President
American Academy of General Practice
Camden, Arkansas
"Is General Practice Here to Stay?"

Eli Lilly & Company of Indianapolis was host to students of Wayne University College of Medicine, Detroit, at Indianapolis, Indiana, on December 14, 15 and 16, 1952. While guests of the company, the future doctors inspected the research laboratories and toured pharmaceutical, biological and antibiotic production facilities of the Lilly establishment.

The Association of American Physicians and Surgeons announces the seventh Annual National Essay Contest for High School Students, to include the tenth through twelfth grades, public and parochial schools; the seventh to ninth grades are optional. This contest is sponsored with the co-operation of the State and County Medical Societies. The subject: "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care."

Six prizes include: the first, $1,000; the second, $500; the third, $100, and three prizes of $25 each. Surveys in 1944 showed that young students were 80 per cent in favor of a Federal system for providing medical services for all. In 1950 the same type survey, conducted by the same group, the percentage had fallen to 55 per cent. These young people are the voters of the future, and it is important that their sociological attitude is factual. This essay contest is primarily for that purpose.

The Michigan member of the Contest Committee for 1953 is Lynn A. Ferguson, M.D., Grand Rapids, Michigan. For further information, write the Association of American Physicians and Surgeons, Inc., 360 North Michigan Ave., Chicago 1, Illinois.

* * *

The Northern Tri State Postgraduate Medical Association will hold its annual meeting at Ann Arbor, Michigan, April 2, 1953. The program has not yet been announced but will extend throughout the day.

For further information, write William Henry Gordon, M.D., 1102 David Whitney Bldg., Detroit 26, Michigan.

GENESEE COUNTY MEDICAL SOCIETY

The Eighth Annual Cancer Day Program

Flint, Michigan

Merliss Brown Auditorium — Hurley Hospital

Wednesday, April 8, 1953

Morning Session—9:30 A.M.

Presiding—L. W. HULL, M.D., Detroit, President-Elect, Michigan State Medical Society

Address of Welcome—A. C. PFEIFER, M.D., Mt. Morris, Mich., President, Genesee County Medical Society

"Cancer of the Pancreas and Biliary Tract"
RICHARD B. CATTELL, M.D., Attending Surgeon, Lahey Clinic, New England Deaconess and New England Baptist Hospitals, Boston, Mass.

"Differential Diagnosis and Treatment of Cancer of the Ovary"
EMIL NOVAK, M.D., Assistant Professor of Gynecology, Johns Hopkins University; Gynecologist-in-Chief, St. Agnes and Bon Secours Hospitals, Baltimore, Md.

"Leukemia, Hodgkin's Disease and Allied Disorders"
CYRUS C. STURGIS, M.D., Professor and Director of Internal Medicine, University of Michigan Medical School and Hospital; Director of The Thomas Henry Simpson Memorial Institute of Medical Research, Ann Arbor, Mich.

Mid-day Recess—12:30 P.M.

Luncheon, Compliments of Hurley Hospital, Flint

Afternoon Session—2:00 P.M.

Presiding—CLIFFORD H. KEENE, M.D., Ann Arbor, Co-Chairman, Cancer Control Committee, Michigan State Medical Society

"The Management of Pain Problems Related to Cancer"
FRANK H. MAYFIELD, M.D., Assistant Professor of Surgery, University of Cincinnati; Neuro-Surgeon, Cincinnati General Hospital, Cincinnati, O.

"The Use of Radioactive Isotopes in the Clinical Aspects of Cancer"
RICHARD H. CHAMBERLAIN, M.D., Associate Professor of Radiology in charge of Radiotherapy, University of Pennsylvania; Director of Radio-Therapeutics, Atomic Energy Commission, Philadelphia, Pa.

Panel Discussion—"Palliation and Terminal Care of Cancer Patients"

Moderator—CHARLES S. KENNEDY, M.D., Emeritus Professor of Surgery, Wayne University Medical School; Emeritus Chief of Staff and Chief of Surgery, Consulting Surgeon, Grace Hospital, Detroit, Mich.

Panel Members: DRS. CATTELL, NOVAK, STURGIS, MAYFIELD and CHAMBERLAIN.

Evening Activities—6:00 P.M.

Social Hour, 6:00 P.M.—Subscription Dinner, 7:00 P.M.
Elks Club

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

OPHTHALMIC PATHOLOGY. An Atlas and Textbook. By Jonas S. Friedenwald; Helenor Campbell Wilder; A. Edward Maumenee; T. E. Sanders; John E. L. Keyes; Michael J. Hogan; W. C. and Ella U. Owens. With the editorial assistance of Helen Knight Steward. Published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. Philadelphia: W. B. Saunders Co., 1952. Price $18.00.

The editors and authors of this volume have produced a most elaborate and satisfactory volume, giving the clinical and pathological descriptions of most of the ophthalmic conditions encountered in a busy practice, not forgetting many of the rarer conditions. The book is divided into eighteen chapters, or sections. The book is large, about nine by twelve, so as to allow space for illustrations. Each chapter consists of text, two columns on a page, followed by numerous plates. Every condition described in the text is well illustrated by slides and sections. There are no pictures of gross specimens. The text is well written, describing the condition, with references to the author who first described it, and continuing the history to the present understanding. In the section on glaucoma is the statement that glaucoma is not a single disease, but a group with a common condition of elevated intraocular tension. The pathological description occupies six pages. Under diabetes the very latest concept of microaneurisms is discussed, with complete elaboration of the condition and pictures of the pathology. The book is much worth while to any ophthalmologist who wishes to understand the conditions he is treatiig.

W.H.

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY. By Joseph J. McConald, M.S., M.Sc.D., M.D. Professor of Surgery, Columbia University; Attending Surgeon, Presbyterian Hospital; New York Director of the Surgical Service, Francis Delafield Hospital, New York, and Joseph G. Chusid, A.B., M.D. Attending Neurologist, St. Vincent's Hospital, New York. Sixth Edition. Los Altos, California: Lange Medical Publications, University Medical Publishers, 1952. Price $4.00.

This manual has grown from a correlative neuroanatomy to that of a neuro-anatomy combined with a functional neurology. It is a bound notebook type of publication now in its sixth edition which speaks for itself in its usefulness and interest. It was originally intended as a help for the student. It has remained as such, but now it has also become a handy reference for those who feel the need, and who does not, of refreshing one's mind. The fundamental facts of the central and peripheral nervous system are presented. The anatomical illustrations are copious and excellent. This book should have a special appeal to the student or physician preparing for the board examinations.

G.K.S.

PRACTICAL DERMATOLOGY For Medical Students and General Practitioners. By George M. Lewis, M.D., F.A.C.P., Professor of Clinical Medicine (Dermatology), Cornell University Medical College; Attending Dermatologist, The New York Hospital; Secretary, the American Board of Dermatology and Syphilology. Philadelphia: W. B. Saunders Co., 1952.

This is an excellent new book for the medical student or non-dermatologist. It stresses clinical features, means of diagnosis and treatment. Each paragraph throughout the book has a heading indicating the contents of the paragraph, which makes for easy reference. The number and quality of the illustrations in this book are hardly surpassed anywhere. Basic fields of histology, mycology, bacteriology, et cetera are omitted, but these are usually of no interest to the readers for whom the book is intended. The book is well-printed and well-bound. This should be a valuable book to the student and general practitioner.

H.E.A.

STANDARD VALUES IN BLOOD. Being the first fascicle of a Handbook of Biological Data. Edited by Errett C. Albritton, A.B., M.D. Fry Professor of Physiology, The George Washington University. Prepared under the Direction of the Committee on the Handbook of Biological Data, American Institute of Biological Sciences the National Research Council. Philadelphia: W. B. Saunders Co., 1952.

This book is exactly what the title implies, and the reliability of the mass of useful data presented is vouchsafed by the fact that it has been collected and sifted by over 600 competent investigators.

The tables deal with various animals, as well as man, and run the gamut from plasma viscosities to the erythrocytic oxygen consumption values of the alligator. The recently discovered rare blood groups are tabulated by frequencies and genetic traits. The material devoted to the bone marow is extensive and excellent, and the effects of radiation on hematopoietic tissues are thoroughly covered in tabular form.

The last forty-five pages are devoted to a well-arranged bibliography. The binding is poor but, since it is to be followed by two other somewhat similar fascicles, it is to be assumed that the purchaser will eventually have all three bound together.

This book is invaluable as an aid in research.

A.A.H.

PARDON MY SNEEZE. By Milton Millman, M.D., Fellow, American College of Allergists, Member, American Academy of Allergy. New York: Doubleday & Company, 1952.

The title of this book tells the subject—allergy. It is a card paper-covered volume of twenty-seven chapters, 217 pages, printed in large, easily read type, with nine illustrations other than the designs for the front and back covers. The whole field of allergy is covered from a definition to diagnosis, tests, food allergies, hay fever, the allergic nose, bronchial asthma, eczema, house dust, and the consideration of treatment, including diets. The style is free and somewhat humorous, which makes for

interesting reading. At the end of the chapter on testing he says: "Can you now see that the best allergist is not necessarily the one with the most needles? The most co-operative patient makes for the best results." The chapter on house dust is worth many times the cost of the book because sufferers from house dust are many, and need very careful handling. This book is thorough, but brief. We believe it would be a most valuable adjunct to any allergist treating patients who are somewhat of a problem because of unusual or baffling conditions.

RYPINS' MEDICAL LICENSURE EXAMINATIONS. Topical Summaries and Questions. By Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edinburgh (Hon.); Former Member, National Board of Medical Examiners, American Board of Internal Medicine, Iowa State Board of Medical Examiners; Professor Emeritus, Theory and Practice of Medicine, College of Medicine, State University of Iowa; Secretary, Federation of State Medical Boards of the United States; Chairman, American Board of Preventive Medicine and Public Health; Iowa State Commissioner of Health. With the collaboration of a Review Panel. Seventh Edition. Philadelphia: J. B. Lippincott Co., 1952. Price $8.00.

Dr. Rypins who was secretary of the New York State Board of Medical Examiners for fifteen years first published a volume on "Medical State Board Examinations," in 1933. He published four editions. This is the seventh of the series, the third by Dr. Bierring. Literally thousands of questions asked on various State Board examinations throughout the country were collected, and a book written covering a review of ten major branches of the medical field, explaining and answering all the questions. This is written in the form of text. At the end of each chapter are several pages of typical answers, so the student preparing for examinations might get an idea of what to expect in questions, and an inkling of satisfactory answers. Ten outstanding teachers have been selected to present the ten branches. This new edition rearranges the fields to fit modern ideas of practice and teaching methods. The book is a very complete review, and quite worth while.

BIOCHEMISTRY FOR MEDICAL STUDENTS. By William Veale Thorpe, M.A. (Cantab.), Ph.D. (Lond.) Reader in Chemical Physiology, University of Birmingham, England. Fifth Edition with 41 illustrations. Philadelphia: J. B. Lippincott Co., 1952. Price $6.00.

This volume is well written and clear. It probably has achieved this perfection by virtue of the revision attendant with five editions. The amount of material covered is amazing, although much of it mentions only the highlights of the particular topic. The chapter on vitamins is very good and also that part of the work dealing with chemistry of nutrition. It is recommended not only for medical students, but also for the average physician as an up-to-date reference book.

A.A.H.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty

WANTED: Nurse anesthetist. Salary $600.00 per month, plus bonus. Brent General Hospital, 16260 Dexter, Detroit 21, Michigan.

WANTED: Registered laboratory technician, white. Afternoon shift. Top salary, meal. Brent General Hospital, 16260 Dexter, Detroit 21, Michigan.

WANTED: Registered nurses, white, desiring one or more days per week, for group nursing; to become hospital's own registry. $16.00 per day, meal, bonus. Brent General Hospital, 16260 Dexter, Detroit 21, Michigan.

WANTED: General practitioner to take over large rural practice netting over $1,200.00 per month. Combined office and residence available. Michigan License necessary. Present doctor being drafted. Draft exempt preferred. Reply Box 3, 606 Townsend Street, Lansing, Michigan.

ALGONAC, MICHIGAN, on St. Clair River, close to Detroit, Mt. Clemens and Port Huron, needs a doctor badly. Village and township population over 5,000—$20,000.00 or more yearly earnings. Apply Secretary, Chamber of Commerce, or phone Algonac 281.

FOR SALE: Home and attached clinic, ivory facebrick. Prominent corner on good business street. Retiring. Terms. Dr. A. I. Frankfurth, 15645 Fenkell Avenue, Detroit, Michigan. Phone VE-6-3515.

MATURE PHYSICIAN—The Battle Creek Sanitarium needs the services of an internist or general practitioner on a full-time basis. No surgery—no house calls—good salary—vacation. This opportunity is particularly suited to a mature man whose health demands that he get away from the pressure of a busy practice. Write or phone the Battle Creek Sanitarium, Arthur Osterholm, Manager, Battle Creek, Michigan.

MIDLAND, MICHIGAN—Professional office space available. New fireproof building. Ready June 1953. Now in blue prints. Contact Mrs. H. V. Sheldon, 3210 Midland Road, Bay City, Michigan.

PHYSICIAN NEEDED IMMEDIATELY to attend populace of Michigan's Beaver Island. State pays salary of $5,808 to $6,576 to supplement fees from practice and provides merit system and retirement benefits. Previous physician remained twenty-nine years. Write or call: Commissioner, Michigan Department of Health, Lansing.

YOUNG DOCTOR wanted for association with internist, Fisher Building, Detroit. Write Box 1, 606 Townsend Street, Lansing 15, Michigan.

FOR RENT OR LEASE—Spacious ground-floor office in fast growing community of suburban Detroit now occupied by Ophthalmologist. Suitable for Ophthalmologist, Otolaryngologist or both. Practice is gratis. Reply: Box 2, 606 Townsend Street, Lansing 15, Michigan.

WANTED A DOCTOR—Pentwater, Michigan, on Lake Michigan and U. S. 31. Population—1200 in winter—5000 in summer. No resident physician since June, 1952. Write or call Pentwater Chamber of Commerce.

THE WELFARE STATE

It is customary to point a finger overseas when we talk about the disadvantages of the Welfare State. But right here at home we also have a striking example of what a Welfare State does for its people. Let's take a look at what the Federal government has done for the American Indian.

Here are some important truths about the Indians whose kindly government proposed, 125 years ago, to help them along briefly and then make them free:

Today a restricted Indian cannot buy, sell, or lease property except with Indian Bureau consent; he cannot have access to his money deposited for him in the Federal Treasury except by act of Congress; he cannot engage in free and unrestricted business enterprise on the reservation because the Indian Bureau has its own specially sponsored corporations to handle business matters for the Indians. He is totally dependent upon the Indian Bureau when he is out of a job, sick, or when incapacitated by old age; he cannot buy, sell, or consume alcoholic beverages either on or off the reservation; if he should happen to be a war veteran he cannot, as a rule, obtain a loan under the GI bill of rights because his property is tied up in Indian Bureau trusteeship. For each individual Indian it takes in most cases a special act of Congress to be freed from the restrictions imposed by the Indian Bureau.

Although the demand to abolish the Indian Bureau has been made in Congress year after year and has failed because so few people are acquainted with or care about the Indian's plight, it is being voiced again this year. Senator George Malone is trying to arouse the public to the danger of any form of government paternalism. "The most difficult thing in the world," he emphasizes, "is to remove a system of any kind which is organized to supervise somebody and handle his money and property, so long as the money and property hold out."

—Dr. George S. Benson, President, Harding College, Searcy, Arkansas, in *GM Folks*, September, 1952.